



## **Prior Authorization Grid**

This is a list of drugs that requires certain criteria to be met before a drug is covered. For example, diagnosis, lab values, or previous treatments tried and failed.

## **Cuadro de Autorización previa**

Esta es una lista de medicamentos que requiere que se cumplan ciertos criterios antes de que se cubra un medicamento. Por ejemplo, diagnóstico, valores de laboratorio o tratamientos previos probados y fracasados.

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## PA Criteria

<b>Prior Authorization Group</b>	ABIRATERONE
<b>Drug Names</b>	ABIRATERONE ACETATE, ZYTIGA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Node-positive (N1), non-metastatic (M0) prostate cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ACITRETIN
<b>Drug Names</b>	ACITRETIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or contraindication to methotrexate or cyclosporine.
<b>Prior Authorization Group</b>	ACTIMMUNE
<b>Drug Names</b>	ACTIMMUNE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Mycosis fungoides, Sezary syndrome.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ADEMPAS
<b>Drug Names</b>	ADEMPAS
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AIMOVIG
<b>Drug Names</b>	AIMOVIG
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Initial 3 Months, Reauthorization Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ALDURAZYME
<b>Drug Names</b>	ALDURAZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For mucopolysaccharidosis I: Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALECENSA
<b>Drug Names</b>	ALECENSA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALOSETRON
<b>Drug Names</b>	ALOSETRON HYDROCHLORIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ALPHA1-PROTEINASE INHIBITOR
<b>Drug Names</b>	ARALAST NP, PROLASTIN-C, ZEMAIRA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALUNBRIG
<b>Drug Names</b>	ALUNBRIG
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AMBRISANTAN
<b>Drug Names</b>	AMBRISANTAN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	AMPHETAMINES
<b>Drug Names</b>	AMPHETAMINE/DEXTROAMPHETA
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has the diagnosis of narcolepsy confirmed by a sleep study.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	APOKYN
<b>Drug Names</b>	APOKYN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ARCALYST
<b>Drug Names</b>	ARCALYST
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
<b>Age Restrictions</b>	For Cryopyrin-Associated Periodic Syndromes (CAPS) and recurrent pericarditis: 12 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	For prevention of gout flares: 4 months. Other: Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ARMODAFINIL
<b>Drug Names</b>	ARMODAFINIL
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ATYPICAL ANTIPSYCHOTICS
<b>Drug Names</b>	FANAPT, FANAPT TITRATION PACK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AURYXIA
<b>Drug Names</b>	AURYXIA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The requested drug is not being prescribed for treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis

<b>Prior Authorization Group</b>	AUSTEDO
<b>Drug Names</b>	AUSTEDO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Tourette's syndrome
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AVASTIN
<b>Drug Names</b>	AVASTIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, leptomeningeal metastases and metastatic spine tumors, malignant pleural mesothelioma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, AIDS-related Kaposi sarcoma, uterine cancer, endometrial cancer, vulvar cancer, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to both Mvasi AND Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.



<b>Prior Authorization Group</b>	AYVAKIT
<b>Drug Names</b>	AYVAKIT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For advanced systemic mastocytosis (AdvSM): 1) the patient has a diagnosis of advanced systemic mastocytosis including aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL) AND 2) the patient has a platelet count of greater than or equal to 50,000/mcL.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group****Drug Names**

B VS. D

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN-PF 7%, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 6/5, CLINIMIX 8/10, CLINIMIX 8/14, CLINISOL SF 15%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DEXTROSE 50%, DEXTROSE 70%, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, EVEROLIMUS, FLUOROURACIL, FREAMINE III, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARAPLATIN, PARICALCITOL, PENTAMIDINE ISETHIONATE, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVER, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TDVAX, TENIVAC, TOPOSAR, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS

**PA Indication Indicator**

All Medically-accepted Indications

**Off-label Uses**

-

**Exclusion Criteria**

-

**Required Medical Information**

-

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

N/A

**Other Criteria**

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

<b>Prior Authorization Group</b>	BALVERSA
<b>Drug Names</b>	BALVERSA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BANZEL
<b>Drug Names</b>	BANZEL, RUFINAMIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	1 year of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BENLYSTA
<b>Drug Names</b>	BENLYSTA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	For patients new to therapy: severe active central nervous system lupus.
<b>Required Medical Information</b>	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid or antimalarial) for SLE OR 2) patient is not currently receiving stable standard therapy regimen for SLE because patient tried and had an inadequate response or intolerance to stable standard therapy regimen. For lupus nephritis: 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid) for lupus nephritis OR 2) patient is not currently receiving a stable standard therapy regimen for lupus nephritis because patient tried and had an inadequate response or intolerance to a stable standard therapy regimen.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BERINERT
<b>Drug Names</b>	BERINERT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hereditary angioedema (HAE): patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BETASERON
<b>Drug Names</b>	BETASERON
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BEXAROTENE
<b>Drug Names</b>	BEXAROTENE, TARGRETIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BOSENTAN
<b>Drug Names</b>	BOSENTAN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Eisenmenger's syndrome
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. For Eisenmenger's syndrome: Patient is diagnosed with Eisenmenger's syndrome, WHO functional class III PAH.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BOSULIF
<b>Drug Names</b>	BOSULIF
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) patient has chronic phase CML (high, intermediate, or low risk for disease progression). If patient has low risk for disease progression (includes newly diagnosed), patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BRAFTOVI
<b>Drug Names</b>	BRAFTOVI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For colorectal cancer, patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600E mutation, 2) The disease is advanced or metastatic, and 3) The requested drug will be used as subsequent therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BRIVIACT
<b>Drug Names</b>	BRIVIACT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	1 month of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BRIVIACT INJ
<b>Drug Names</b>	BRIVIACT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	1 month of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BRUKINSA
<b>Drug Names</b>	BRUKINSA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BUPRENORPHINE
<b>Drug Names</b>	BUPRENORPHINE HCL
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for the treatment of opioid use disorder AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 4) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CABOMETYX
<b>Drug Names</b>	CABOMETYX
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-small cell lung cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive. For hepatocellular carcinoma: The patient has been previously treated with sorafenib.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CALCIPOTRIENE
<b>Drug Names</b>	CALCIPOTRIENE, CALCITRENE, ENSTILAR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CALQUENCE
<b>Drug Names</b>	CALQUENCE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CAPRELSA
<b>Drug Names</b>	CAPRELSA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC: the requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	CARBAGLU
<b>Drug Names</b>	CARBAGLU
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CAYSTON
<b>Drug Names</b>	CAYSTON
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CERDELGA
<b>Drug Names</b>	CERDELGA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CEREZYME
<b>Drug Names</b>	CEREZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Type 3 Gaucher disease
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CHANTIX
<b>Drug Names</b>	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA, VARENICLINE TARTRATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CLOBAZAM
<b>Drug Names</b>	CLOBAZAM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CLOMIPRAMINE
<b>Drug Names</b>	CLOMIPRAMINE HCL
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Depression, Panic Disorder
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CLORAZEPATE
<b>Drug Names</b>	CLORAZEPATE DIPOTASSIUM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR The patient has experienced an inadequate treatment response, intolerance, or a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

<b>Prior Authorization Group</b>	CLOZAPINE ODT
<b>Drug Names</b>	CLOZAPINE ODT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	COMETRIQ
<b>Drug Names</b>	COMETRIQ
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	COPIKTRA
<b>Drug Names</b>	COPIKTRA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, splenic marginal zone lymphoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For follicular lymphoma: the requested drug will be used as second-line or subsequent therapy. For gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma: the requested drug will be used as subsequent therapy after at least 2 prior therapies.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	COTELLIC
<b>Drug Names</b>	COTELLIC
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CYSTADROPS
<b>Drug Names</b>	CYSTADROPS
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CYSTAGON
<b>Drug Names</b>	CYSTAGON
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For nephropathic cystinosis: Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CYSTARAN
<b>Drug Names</b>	CYSTARAN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DALFAMPRIDINE
<b>Drug Names</b>	DALFAMPRIDINE ER
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient meets the following: patient demonstrates sustained walking impairment. For continuation of therapy, patient meets the following: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	DAURISMO
<b>Drug Names</b>	DAURISMO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Post remission therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory disease as a component of repeating the initial successful induction regimen for AML.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acute myeloid leukemia: 1) the requested medication must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, and 3) the requested medication will be used as treatment for induction therapy, post-remission therapy, or relapsed or refractory disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DEFERASIROX
<b>Drug Names</b>	DEFERASIROX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DEMSEER
<b>Drug Names</b>	METYROSINE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	DESVENLAFAXINE
<b>Drug Names</b>	DESVENLAFAXINE ER
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DHE NASAL
<b>Drug Names</b>	DIHYDROERGOTAMINE MESYLAT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient experienced an inadequate treatment response, intolerance, or contraindication to one triptan 5-HT1 receptor agonist
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DIACOMIT
<b>Drug Names</b>	DIACOMIT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	DIAZEPAM
<b>Drug Names</b>	DIAZEPAM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR The patient has experienced an inadequate treatment response, intolerance, or a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of spasticity caused by upper motor neuron disorders (e.g., cerebral palsy and paraplegia), athetosis, or stiff-man syndrome OR 4) For use as an adjunct for the relief of skeletal muscle spasms due to reflex spasm to local pathology (e.g., inflammation of the muscles or joints, or secondary to trauma) OR 5) For adjunctive therapy in the treatment of convulsive disorders OR 6) For the short-term relief of the symptoms of anxiety.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Short-term relief anx-1 mo, skeletal muscles spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
<b>Prior Authorization Group</b>	DICLOFENAC GEL 1%
<b>Drug Names</b>	DICLOFENAC SODIUM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists, or elbows AND 2) Treatment with the requested drug is necessary due to concern of an intolerance or a contraindication to two oral nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	DOPTelet
<b>Drug Names</b>	DOPTelet
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For thrombocytopenia associated with chronic liver disease: Baseline platelet (plt) count prior to a scheduled procedure is less than 50,000/mcL. For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused plt count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DRIZALMA
<b>Drug Names</b>	DRIZALMA SPRINKLE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Cancer pain, chemotherapy-induced neuropathic pain
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)
<b>Age Restrictions</b>	Generalized Anxiety Disorder - 7 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	EMSAM
<b>Drug Names</b>	EMSAM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion OR 2) Patient is unable to swallow oral formulations.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ENBREL
<b>Drug Names</b>	ENBREL, ENBREL MINI, ENBREL SURECLICK
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Severe, refractory hidradenitis suppurativa, graft versus host disease
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ENDARI
<b>Drug Names</b>	ENDARI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	5 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	EPCLUSA
<b>Drug Names</b>	EPCLUSA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD-IDSA guidance.
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	EPIDIOLEX
<b>Drug Names</b>	EPIDIOLEX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	EPO
<b>Drug Names</b>	PROCRT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
<b>Exclusion Criteria</b>	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
<b>Required Medical Information</b>	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	16 weeks
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin treatment in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, human immunodeficiency virus (HIV), hepatitis C treatment, anemia due to myelosuppressive cancer chemotherapy, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than 12 g/dL.
<b>Prior Authorization Group</b>	ERIVEDGE
<b>Drug Names</b>	ERIVEDGE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Adult medulloblastoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Adult medulloblastoma: patient has received chemotherapy previously AND has tumor(s) with mutations in the sonic hedgehog pathway
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ERLEADA
<b>Drug Names</b>	ERLEADA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For all indications: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ERLOTINIB
<b>Drug Names</b>	ERLOTINIB HYDROCHLORIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced non-small cell lung cancer (NSCLC), recurrent chordoma, renal cell carcinoma (RCC), brain metastases from NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the member has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, or metastatic.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ESBRIET
<b>Drug Names</b>	ESBRIET
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	EVEROLIMUS
<b>Drug Names</b>	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: The disease is relapsed or metastatic. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	EXKIVITY
<b>Drug Names</b>	EXKIVITY
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FABRAZYME
<b>Drug Names</b>	FABRAZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Fabry disease: diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FARYDAK
<b>Drug Names</b>	FARYDAK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FASENRA
<b>Drug Names</b>	FASENRA, FASENRA PEN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For severe asthma: For initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). For continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	FENTANYL PATCH
<b>Drug Names</b>	FENTANYL
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FETZIMA
<b>Drug Names</b>	FETZIMA, FETZIMA TITRATION PACK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FINTEPLA
<b>Drug Names</b>	FINTEPLA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FORTEO
<b>Drug Names</b>	FORTEO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
<b>Other Criteria</b>	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

<b>Prior Authorization Group</b>	FOTIVDA
<b>Drug Names</b>	FOTIVDA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FYCOMPA
<b>Drug Names</b>	FYCOMPA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	Partial-onset seizures: 4 years of age or older, Primary generalized tonic-clonic seizures: 12 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GATTEX
<b>Drug Names</b>	GATTEX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For short bowel syndrome (SBS) initial therapy: Adult patients were dependent on parenteral support for at least 12 months. Pediatric patients were dependent on nutrition/IV fluids to account for at least 30 percent of caloric and/or fluid/electrolyte needs. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GAVRETO
<b>Drug Names</b>	GAVRETO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GILENYA
<b>Drug Names</b>	GILENYA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GILOTRIF
<b>Drug Names</b>	GILOTRIF
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Brain metastases from non-small cell lung cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or 2) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC: Patient has a known sensitizing EGFR mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GLATIRAMER
<b>Drug Names</b>	GLATIRAMER ACETATE, GLATOPA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GROWTH HORMONE
<b>Drug Names</b>	GENOTROPIN, GENOTROPIN MINIQICK
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	Pediatric patients with closed epiphyses (except in patients with PWS).
<b>Required Medical Information</b>	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
<b>Age Restrictions</b>	SGA: 2 years of age or older
<b>Prescriber Restrictions</b>	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

<b>Prior Authorization Group</b>	HAEGARDA
<b>Drug Names</b>	HAEGARDA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation, OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	HARVONI
<b>Drug Names</b>	HARVONI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	HERCEPTIN
<b>Drug Names</b>	HERCEPTIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
<b>Prior Authorization Group</b>	HERCEPTIN HYLECTA
<b>Drug Names</b>	HERCEPTIN HYLECTA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months, Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

<b>Prior Authorization Group</b>	HERZUMA
<b>Drug Names</b>	HERZUMA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
<b>Prior Authorization Group</b>	HETLIOZ
<b>Drug Names</b>	HETLIOZ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) for initial therapy and continuation of therapy, the patient has a confirmed diagnosis of SMS AND 2) if currently on therapy with the requested drug, the patient experiences improvement in the quality of sleep since starting therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Initiation: 6 Months, Renewal: Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	HRM-ANTICONVULSANTS
<b>Drug Names</b>	PHENOBARBITAL, PHENOBARBITAL SODIUM
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Epilepsy
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Prior Authorization Group</b>	HRM-ANTIPARKINSON
<b>Drug Names</b>	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has tried the non-HRM alternative drug amantadine AND 5) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

<b>Prior Authorization Group</b>	HRM-CYPROHEPTADINE
<b>Drug Names</b>	CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Pruritus, spasticity due to spinal cord injury
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Prior Authorization Group</b>	HRM-DIPYRIDAMOLE
<b>Drug Names</b>	DIPYRIDAMOLE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-GUANFACINE ER
<b>Drug Names</b>	GUANFACINE ER
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Prior Authorization Group</b>	HRM-GUANFACINE IR
<b>Drug Names</b>	GUANFACINE HCL
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-HYDROXYZINE
<b>Drug Names</b>	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 5) The patient has acute anxiety AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 7) If being requested for pruritus, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

<b>Prior Authorization Group</b>	HRM-HYDROXYZINE INJ
<b>Drug Names</b>	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	<p>Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.</p> <p>Anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 5) The patient has acute anxiety AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.</p>
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)</p>

<b>Prior Authorization Group</b>	HRM-HYPNOTICS
<b>Drug Names</b>	ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 3) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
<b>Prior Authorization Group</b>	HRM-METHYLDOPA
<b>Drug Names</b>	METHYLDOPA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-PROMETHAZINE
<b>Drug Names</b>	PROMETHAZINE HCL, PROMETHAZINE HCL PLAIN, PROMETHAZINE HYDROCHLORID
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	<p>Rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.</p>
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)</p>

<b>Prior Authorization Group</b>	HRM-SCOPOLAMINE
<b>Drug Names</b>	SCOPOLAMINE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Excessive salivation
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b>Prior Authorization Group</b>	HRM-SKELETAL MUSCLE RELAXANTS
<b>Drug Names</b>	CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL, VANADOM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.



<b>Prior Authorization Group</b>	HUMIRA
<b>Drug Names</b>	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PEDIATRIC UC S, HUMIRA PEN-PS/UV STARTER
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Axial spondyloarthritis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	HYPNOTIC BENZODIAZEPINES
<b>Drug Names</b>	TEMAZEPAM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 3) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older OR 4) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
<b>Prior Authorization Group</b>	IBRANCE
<b>Drug Names</b>	IBRANCE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Unresectable well-differentiated/dedifferentiated liposarcoma, recurrent hormone receptor (HR)-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with an aromatase inhibitor or fulvestrant.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ICATIBANT
<b>Drug Names</b>	ICATIBANT ACETATE, SAJAZIR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ICLUSIG
<b>Drug Names</b>	ICLUSIG
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Follow-up therapy after hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML) and ALL patients.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	IDHIFA
<b>Drug Names</b>	IDHIFA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Newly-diagnosed acute myeloid leukemia
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient is 60 years of age or older with newly-diagnosed AML and meets one of the following: a) patient has comorbidities that preclude use of intensive induction chemotherapy, or b) patient declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-remission therapy following response to previous lower intensity therapy with the same regimen, OR 3) patient has relapsed or refractory AML.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IMATINIB
<b>Drug Names</b>	IMATINIB MESYLATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, melanoma, AIDS-related Kaposi sarcoma, and chronic myelomonocytic leukemia.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma: c-Kit mutation is positive.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

IMBRUVICA

IMBRUVICA

All FDA-approved Indications, Some Medically-accepted Indications

Gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma.

**Exclusion Criteria**

-

**Required Medical Information**

For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: 1) the disease is relapsed or refractory and 2) the requested drug is used as a single agent. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. For high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For follicular lymphoma: the requested drug will be used as a single agent.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

-

<b>Prior Authorization Group</b>	INCRELEX
<b>Drug Names</b>	INCRELEX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For renewal, patient is experiencing improvement.
<b>Prior Authorization Group</b>	INGREZZA
<b>Drug Names</b>	INGREZZA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	INLYTA
<b>Drug Names</b>	INLYTA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Papillary, Hurthle cell, or follicular thyroid carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	INQOVI
<b>Drug Names</b>	INQOVI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	INREBIC
<b>Drug Names</b>	INREBIC
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IR BEFORE ER
<b>Drug Names</b>	HYDROCODONE BITARTRATE ER, HYSINGLA ER, METHADONE HCL, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	IRESSA
<b>Drug Names</b>	IRESSA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from epidermal growth factor receptor (EGFR) mutation-positive NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC (including brain metastases from NSCLC), patient has a sensitizing EGFR mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ISOTRETINOIN
<b>Drug Names</b>	ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Refractory acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ITRACONAZOLE
<b>Drug Names</b>	ITRACONAZOLE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea capitis, Tinea manuum/Tinea pedis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	IVERMECTIN TAB
<b>Drug Names</b>	IVERMECTIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IVIG
<b>Drug Names</b>	BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

<b>Prior Authorization Group</b>	JAKAFI
<b>Drug Names</b>	JAKAFI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Low-risk myelofibrosis, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, or pediatric acute lymphoblastic leukemia (ALL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea. For pediatric acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	JUXTAPID
<b>Drug Names</b>	JUXTAPID
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For initiation of therapy to treat homozygous familial hypercholesterolemia: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin or experienced statin-intolerance, fibrate, bile acid sequestrant, ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the Food and Drug Administration (FDA), AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy to treat HoFH: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or LDL receptor adaptor protein/ARH gene locus, OR 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of familial hypercholesterolemia (FH) by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature atherosclerotic cardiovascular disease (ASCVD) [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative 60 years of age or younger or in a second degree relative 50 years of age or younger, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

<b>Prior Authorization Group</b>	KALYDECO
<b>Drug Names</b>	KALYDECO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis (CF): The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
<b>Age Restrictions</b>	4 months of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The requested medication will not be used in combination with other medications containing ivacaftor.
<b>Prior Authorization Group</b>	KANJINTI
<b>Drug Names</b>	KANJINTI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b>Prior Authorization Group</b>	KETOCONAZOLE
<b>Drug Names</b>	KETOCONAZOLE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Cushing's syndrome.
<b>Exclusion Criteria</b>	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.
<b>Required Medical Information</b>	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

KEYTRUDA

KEYTRUDA

All FDA-approved Indications, Some Medically-accepted Indications

Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, uveal melanoma, Ewing sarcoma, osteosarcoma, testicular cancer, anal carcinoma, adrenal gland tumors, penile cancer, central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer (NSCLC), pancreatic adenocarcinoma, hepatobiliary cancers (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer), malignant pleural mesothelioma, vulvar cancer, thymic carcinoma, Mycosis Fungoides/Sezary syndrome, T-cell lymphomas (extranodal natural killer [NK]/T-cell lymphoma, nasal type), gestational trophoblastic neoplasia, poorly differentiated neuroendocrine carcinoma/large or small cell carcinoma.

**Exclusion Criteria**

-

**Required Medical Information**

For cutaneous melanoma: Disease is unresectable or metastatic. For adjuvant treatment of melanoma: 1) The disease has spread to lymph nodes and 2) The requested drug will be used following complete lymph node resection or complete resection of metastatic disease. For NSCLC: Patient must meet any of the following conditions: 1) Will be used in combination with pemetrexed and carboplatin or cisplatin following epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) therapy (if EGFR or ALK positive) for recurrent, advanced, or metastatic nonsquamous NSCLC, OR 2) Will be used with carboplatin or cisplatin and paclitaxel or paclitaxel protein-bound for recurrent, advanced, or metastatic squamous NSCLC, OR 3) Will be used as a single agent for recurrent, advanced, or metastatic NSCLC expressing programmed death ligand 1 (PD-L1) (Tumor Proportion Score [TPS] greater than or equal to 1%) following EGFR or ALK therapy (if EGFR or ALK positive), OR 4) Will be used for continuation maintenance therapy for recurrent, advanced or metastatic disease. For head and neck squamous cell carcinoma: Disease is unresectable, metastatic, or second primary. For classical Hodgkin lymphoma: The disease is relapsed or refractory. For urothelial carcinoma (other than non-muscle invasive bladder cancer [NMIBC] with carcinoma in situ [CIS]): 1) Patient is not eligible for cisplatin and tumor expresses PD-L1 (Combined Positive Score [CPS] greater than or equal to 10), OR 2) Patient is not eligible for any platinum-containing chemotherapy, OR 3) Disease has progressed during, following, or within 12 months of neoadjuvant or adjuvant platinum therapy. For NMIBC with CIS: Disease is high-risk and Bacillus Calmette-Guerin (BCG)-unresponsive AND patient is ineligible for or has elected not to undergo cystectomy. For colorectal cancer: 1) Disease is unresectable or metastatic, AND 2) Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

For solid tumors (including Ewing sarcoma, osteosarcoma, adrenal gland tumors,

penile cancer): 1) Disease is unresectable or metastatic, AND 2) Tumor is MSI-H or dMMR or tumor mutational burden-high (greater than or equal to 10 mutations per megabase), AND 3) Disease has progressed following prior treatment and patient has no satisfactory alternative treatment options. For gastric, esophagogastric junction, and esophageal cancer: 1) Member is not a surgical candidate or disease is recurrent, locally advanced, or metastatic, AND 2) Tumor is MSI-H or dMMR OR tumor expresses PD-L1 (CPS greater than or equal to 1) OR the requested drug will be used in combination with chemotherapy. For cervical cancer: Disease is recurrent or metastatic AND one of the following: 1) Tumor is MSI-H or dMMR, OR 2) Tumor expresses PD-L1 (CPS greater than or equal to 1) and disease has progressed on or after chemotherapy. For primary mediastinal large B-cell lymphoma: Disease is relapsed or refractory. For hepatocellular carcinoma: Patient was previously treated with sorafenib. For kidney cancer: The requested drug will be used in combination with axitinib or lenvatinib. For small cell lung cancer: Disease is relapsed, primary progressive, or metastatic. For CNS brain metastases: The requested drug will be used for treatment of brain metastases in patients with melanoma or NSCLC.

**Prior Authorization Group**  
**Drug Names**

KISQALI  
KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE

**PA Indication Indicator**  
**Off-label Uses**

All FDA-approved Indications

**Exclusion Criteria**

-

**Required Medical Information**

-

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

For treatment of breast cancer using Kisqali (ribociclib) in combination with an aromatase inhibitor or Kisqali Femara Co-Pack (ribociclib and letrozole) as initial endocrine-based therapy, one the following criteria must be met: 1) the patient is pre- or peri-menopausal, OR 2) the patient is postmenopausal and the patient has experienced disease progression on Ibrance (palbociclib) or Verzenio (abemaciclib) or an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib). For treatment of breast cancer with Kisqali (ribociclib) in combination with fulvestrant, one of the following criteria must met: 1) the requested drug is being used with fulvestrant as initial endocrine-based therapy in a postmenopausal patient, OR 2) the requested drug is being used following disease progression on endocrine therapy in a postmenopausal patient and the patient has experienced disease progression on Ibrance (palbociclib) OR Verzenio (abemaciclib) OR an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib).

<b>Prior Authorization Group</b>	KORLYM
<b>Drug Names</b>	KORLYM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	KUVAN
<b>Drug Names</b>	SAPROPTERIN DIHYDROCHLORI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For phenylketonuria: For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Initial: 2 months. All others: Plan Year.
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	KYNMOBI
<b>Drug Names</b>	KYNMOBI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	LENVIMA
<b>Drug Names</b>	LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Medullary thyroid carcinoma, anaplastic thyroid carcinoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is radioactive iodine-refractory and unresectable, locally recurrent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma: disease is advanced or relapsed.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	LIDOCAINE PATCHES
<b>Drug Names</b>	LIDOCAINE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	LONSURF
<b>Drug Names</b>	LONSURF
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For colorectal cancer: The disease is unresectable advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	LORBRENA
<b>Drug Names</b>	LORBRENA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Repressor of silencing (ROS)-1 rearrangement-positive metastatic NSCLC following progression on crizotinib, entrectinib, or ceritinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	LUMAKRAS
<b>Drug Names</b>	LUMAKRAS
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	LUMIZYME
<b>Drug Names</b>	LUMIZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Pompe disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	LUPRON
<b>Drug Names</b>	LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids.
<b>Age Restrictions</b>	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	LYNPARZA
<b>Drug Names</b>	LYNPARZA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For breast cancer the disease must be: 1) BRCA 1/2-germline mutated, and 2) recurrent or metastatic
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	LYRICA CR
<b>Drug Names</b>	LYRICA CR, PREGABALIN ER
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	MAVYRET
<b>Drug Names</b>	MAVYRET
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C).
<b>Required Medical Information</b>	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD-IDSA guidance.
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	MEGESTROL
<b>Drug Names</b>	MEGESTROL ACETATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	MEKINIST
<b>Drug Names</b>	MEKINIST
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Brain metastases from melanoma, uveal melanoma, colorectal cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For brain metastasis from melanoma or for adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer or for anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent. For unresectable advanced or metastatic colorectal cancer, the tumor is positive for a BRAF V600E activating mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	MEKTOVI
<b>Drug Names</b>	MEKTOVI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Colorectal cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For colorectal cancer, patient must meet all of the following criteria: 1) The requested drug is used in combination with encorafenib, 2) Tumor is positive for BRAF V600E mutation, and 3) The requested drug will be used as subsequent therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	MEMANTINE
<b>Drug Names</b>	MEMANTINE HCL TITRATION P, MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This edit only applies to patients less than 30 years of age.
<b>Prior Authorization Group</b>	METHYLPHENIDATE
<b>Drug Names</b>	DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HYDROC, METADATE ER, METHYLPHENIDATE HYDROCHLO
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has the diagnosis of narcolepsy confirmed by a sleep study and the request is not for a dexamethylphenidate product OR 3) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	MIGLUSTAT
<b>Drug Names</b>	MIGLUSTAT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	MONJUVI
<b>Drug Names</b>	MONJUVI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	MVASI
<b>Drug Names</b>	MVASI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, leptomeningeal metastases and metastatic spine tumors, malignant pleural mesothelioma, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, including the following cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, AIDS-related Kaposi sarcoma, uterine cancer, endometrial cancer, vulvar cancer, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity, hepatocellular carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

<b>Prior Authorization Group</b>	NAGLAZYME
<b>Drug Names</b>	NAGLAZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For mucopolysaccharidosis VI disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NATPARA
<b>Drug Names</b>	NATPARA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism.
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NERLYNX
<b>Drug Names</b>	NERLYNX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	NEXAVAR
<b>Drug Names</b>	NEXAVAR
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, solitary fibrous tumor, and hemangiopericytoma subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For thyroid carcinoma: Histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia, any of the following criteria must be met: 1) The requested drug is used in combination with azactidine or decitabine for low-intensity treatment induction or post-remission therapy AND the patient is 60 years of age or older with FLT3-ITD mutation, OR 2) The disease is relapsed/refractory AND the requested drug is a component of repeating the initial successful induction if late relapse (greater than or equal to 12 months), OR 3) The disease is relapsed/refractory AND the requested drug is used in combination with azactidine or decitabine if the patient is FLT3-ITD mutation positive.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NINLARO
<b>Drug Names</b>	NINLARO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Systemic light chain amyloidosis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone OR cyclophosphamide and dexamethasone OR as a single agent.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	NITISINONE
<b>Drug Names</b>	NITISINONE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NORTHERA
<b>Drug Names</b>	DROXIDOPA, NORTHERA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For neurogenic orthostatic hypotension (NOH): Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. For both initial and continuation of therapy for NOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NUBEQA
<b>Drug Names</b>	NUBEQA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	NUEDEXTA
<b>Drug Names</b>	NUEDEXTA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	NUPLAZID
<b>Drug Names</b>	NUPLAZID
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	OCTREOTIDE
<b>Drug Names</b>	OCTREOTIDE ACETATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Meningiomas, thymomas and thymic carcinomas, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, lung, thymus (carcinoid tumors) or unresected primary gastrinoma, NETs of the pancreas, and pheochromocytoma/paraganglioma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

<b>Prior Authorization Group</b>	ODOMZO
<b>Drug Names</b>	ODOMZO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	OFEV
<b>Drug Names</b>	OFEV
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	OGIVRI
<b>Drug Names</b>	OGIVRI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b>Prior Authorization Group</b>	OMNIPOD
<b>Drug Names</b>	OMNIPOD 5 PACK, OMNIPOD DASH 5 PACK, OMNIPOD STARTER KIT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has diabetes requiring insulin management with multiple daily injections AND 2) The patient is self-testing glucose levels 4 or more times per day AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For continuation of therapy with an insulin pump, the patient has stable or improved glycemic control.
<b>Prior Authorization Group</b>	ONTRUZANT
<b>Drug Names</b>	ONTRUZANT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b>Prior Authorization Group</b>	ONUREG
<b>Drug Names</b>	ONUREG
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	OPSUMIT
<b>Drug Names</b>	OPSUMIT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ORAL-INTRANASAL FENTANYL
<b>Drug Names</b>	FENTANYL CITRATE ORAL TRA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.] AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.]
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ORGOVYX
<b>Drug Names</b>	ORGOVYX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ORKAMBI
<b>Drug Names</b>	ORKAMBI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
<b>Prior Authorization Group</b>	OSPHENA
<b>Drug Names</b>	OSPHENA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	OXANDROLONE
<b>Drug Names</b>	OXANDROLONE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Cachexia associated with AIDS (HIV wasting) or to enhance growth in patients with Turner's Syndrome.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Coverage will be denied if request is for an indication excluded from Part D.



<b>Prior Authorization Group</b>	PANRETIN
<b>Drug Names</b>	PANRETIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PEGASYS
<b>Drug Names</b>	PEGASYS
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis), systemic mastocytosis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PEMAZYRE
<b>Drug Names</b>	PEMAZYRE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	PHENYLBUTYRATE
<b>Drug Names</b>	SODIUM PHENYLBUTYRATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PHESGO
<b>Drug Names</b>	PHESGO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PIQRAY
<b>Drug Names</b>	PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	POMALYST
<b>Drug Names</b>	POMALYST
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi sarcoma, patient meets one of the following: 1) patient has acquired immunodeficiency syndrome (AIDS), or 2) patient is negative for human immunodeficiency virus (HIV).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PRALUENT
<b>Drug Names</b>	PRALUENT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	PREGABALIN
<b>Drug Names</b>	PREGABALIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Cancer-related neuropathic pain, cancer treatment related neuropathic pain.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for the management of postherpetic neuralgia, neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain or cancer treatment related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or management of neuropathic pain associated with spinal cord injury.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	PROMACTA
<b>Drug Names</b>	PROMACTA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
<b>Other Criteria</b>	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL)
<b>Prior Authorization Group</b>	PULMOZYME
<b>Drug Names</b>	PULMOZYME
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

<b>Prior Authorization Group</b>	QINLOCK
<b>Drug Names</b>	QINLOCK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	QUETIAPINE XR
<b>Drug Names</b>	QUETIAPINE FUMARATE ER
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	QUININE SULFATE
<b>Drug Names</b>	QUININE SULFATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Babesiosis, uncomplicated Plasmodium vivax malaria.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	REGRANEX
<b>Drug Names</b>	REGRANEX
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	20 weeks
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	RELISTOR INJ
<b>Drug Names</b>	RELISTOR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik) OR 6) The patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	4 months
<b>Other Criteria</b>	-

**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

REMICADE

REMICADE

All FDA-approved Indications, Some Medically-accepted Indications

Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis

**Exclusion Criteria**

-

**Required Medical Information**

For moderately to severely active Crohn's disease (new starts only): 1) Pt has fistulizing disease, OR 2) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 3) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or contraindication to MTX or leflunomide AND 2) pt meets ANY of the following: a) inadequate response, intolerance or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic DMARD as first-line therapy. For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.



**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

RENFLEXIS

RENFLEXIS

All FDA-approved Indications, Some Medically-accepted Indications

Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis

**Exclusion Criteria**

-

**Required Medical Information**

For moderately to severely active Crohn's disease (new starts only): 1) Pt has fistulizing disease, OR 2) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 3) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or contraindication to MTX or leflunomide AND 2) pt meets ANY of the following: a) inadequate response, intolerance or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic DMARD as first-line therapy. For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

-



<b>Prior Authorization Group</b>	RETEVMO
<b>Drug Names</b>	RETEVMO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
<b>Age Restrictions</b>	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	REVLIMID
<b>Drug Names</b>	REVLIMID
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, myeloproliferative neoplasms, non-Hodgkin's lymphoma with the following subtypes: acquired immunodeficiency syndrome (AIDS)-related diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL), hepatosplenic gamma-delta T-cell lymphoma, high-grade B-cell lymphomas.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia per the International Prognostic Scoring System (IPSS) scale
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	REZUROCK
<b>Drug Names</b>	REZUROCK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

RIABNI

RIABNI

All FDA-approved Indications, Some Medically-accepted Indications

Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, and immune checkpoint inhibitor-related toxicities

**Exclusion Criteria**

**Required Medical Information**

-

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

**Other Criteria**

Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year

For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to both Truxima AND Ruxience and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b>Prior Authorization Group</b>	RINVOQ
<b>Drug Names</b>	RINVOQ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

RITUXAN

RITUXAN

All FDA-approved Indications, Some Medically-accepted Indications

Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, and immune checkpoint inhibitor-related toxicities

**Exclusion Criteria**

**Required Medical Information**

-

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

**Other Criteria**

Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year

For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to both Truxima AND Ruxience and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b>Prior Authorization Group</b>	RITUXAN HYCELA
<b>Drug Names</b>	RITUXAN HYCELA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma, Burkitt lymphoma, Castleman's disease (CD), high-grade B-cell lymphoma, small lymphocytic lymphoma (SLL), gastric mucosa-associated lymphoid tissue (MALT) lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), post-transplant lymphoproliferative disorder (PTLD), splenic marginal zone lymphoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ROZLYTREK
<b>Drug Names</b>	ROZLYTREK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	RUBRACA
<b>Drug Names</b>	RUBRACA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

RUXIENCE

RUXIENCE

All FDA-approved Indications, Some Medically-accepted Indications

Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and pemphigus vulgaris

**Exclusion Criteria**

**Required Medical Information**

-

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

-

-

Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year

-

<b>Prior Authorization Group</b>	RYDAPT
<b>Drug Names</b>	RYDAPT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Relapsed or refractory acute myeloid leukemia
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	SIGNIFOR
<b>Drug Names</b>	SIGNIFOR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	SILDENAFIL
<b>Drug Names</b>	SILDENAFIL CITRATE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	SIRTURO
<b>Drug Names</b>	SIRTURO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	SKYRIZI
<b>Drug Names</b>	SKYRIZI, SKYRIZI PEN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	SOMATULINE DEPOT
<b>Drug Names</b>	SOMATULINE DEPOT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, lung, thymus (carcinoid tumors) or unresected primary gastrinoma, NETs of the pancreas, and pheochromocytoma/paraganglioma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
<b>Prior Authorization Group</b>	SOMAVERT
<b>Drug Names</b>	SOMAVERT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

<b>Prior Authorization Group</b>	SPRYCEL
<b>Drug Names</b>	SPRYCEL
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) for chronic phase CML (includes newly diagnosed), the patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For gastrointestinal stromal tumor (GIST), patient must have progressed on imatinib, sunitinib, or regorafenib.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	STELARA
<b>Drug Names</b>	STELARA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For moderate to severe plaque psoriasis (new starts): the patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active psoriatic arthritis (PsA) (new starts): the patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active Crohn's disease (new starts): patient had an inadequate response, intolerance, or contraindication to Humira (adalimumab). For moderately to severely active ulcerative colitis (new starts): patient had an inadequate response, intolerance, or contraindication to both Humira (adalimumab) and Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
<b>Prior Authorization Group</b>	STIVARGA
<b>Drug Names</b>	STIVARGA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Progressive gastrointestinal stromal tumors (GIST), retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, and soft tissue sarcomas of the extremities, superficial trunk, head and neck, unresectable or advanced colorectal cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	SUTENT
<b>Drug Names</b>	SUNITINIB MALATE, SUTENT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and hemangiopericytoma subtypes), gastrointestinal stromal tumor, recurrent chordoma, thymic carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For renal cell carcinoma, any of the following criteria must be met: 1) The disease is relapsed or metastatic, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	SYMDEKO
<b>Drug Names</b>	SYMDEKO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The requested medication will not be used in combination with other medications containing ivacaftor.
<b>Prior Authorization Group</b>	SYMPAZAN
<b>Drug Names</b>	SYMPAZAN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	SYNRIBO
<b>Drug Names</b>	SYNRIBO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TABRECTA
<b>Drug Names</b>	TABRECTA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Treatment of recurrent or advanced non-small cell lung cancer (NSCLC).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TAFINLAR
<b>Drug Names</b>	TAFINLAR
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), colorectal cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For brain metastases from melanoma or for adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology. For unresectable advanced or metastatic colorectal cancer, the tumor is positive for a BRAF V600E activating mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TAGRISSO
<b>Drug Names</b>	TAGRISSO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, brain metastases from EGFR T790M mutation-positive NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For recurrent, advanced or metastatic NSCLC (including brain metastases from NSCLC), patient must have a sensitizing EGFR mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TALTZ
<b>Drug Names</b>	TALTZ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderate to severe plaque psoriasis (new starts only): At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
<b>Age Restrictions</b>	For plaque psoriasis: 6 years of age or older. Other: 18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For moderate to severe plaque psoriasis (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active ankylosing spondylitis (new starts only): the patient had an inadequate response, intolerance, or contraindication to either Enbrel (etanercept) or Humira (adalimumab). For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active axial spondyloarthritis (new starts only): Patient meets any of the following: 1) has an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial or 2) has an intolerance or contraindication to NSAIDs.

<b>Prior Authorization Group</b>	TALZENNA
<b>Drug Names</b>	TALZENNA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent, BRCA 1/2-germline mutated breast cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TASIGNA
<b>Drug Names</b>	TASIGNA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) for chronic phase CML (includes newly diagnosed), the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TAZAROTENE
<b>Drug Names</b>	TAZAROTENE, TAZORAC
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	TAZVERIK
<b>Drug Names</b>	TAZVERIK
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TECENTRIQ
<b>Drug Names</b>	TECENTRIQ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For urothelial carcinoma, patient meets one of the following criteria: 1) Patient is ineligible for cisplatin therapy and tumors express PD-L1, OR 2) Patient is ineligible for any platinum containing chemotherapy, OR 3) The requested medication will be used as subsequent therapy following platinum-containing chemotherapy. For non-small cell lung cancer (NSCLC), patient meets one of the following criteria: 1) The requested medication will be used as treatment for NSCLC AND patients with EGFR or ALK positive disease must have received previous EGFR or ALK therapy, OR 2) The requested medication will be used as continuation maintenance therapy when tumor response or stable disease is achieved following initial systemic therapy, OR 3) The requested medication will be used as subsequent therapy for recurrent, advanced, or metastatic NSCLC.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TEMAZEPAM 30MG
<b>Drug Names</b>	TEMAZEPAM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 3) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older. OR 4) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
<b>Prior Authorization Group</b>	TEPMETKO
<b>Drug Names</b>	TEPMETKO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

**Exclusion Criteria**

**Required Medical Information**

TESTOSTERONE CYPIONATE INJ

TESTOSTERONE CYPIONATE

All FDA-approved Indications, Some Medically-accepted Indications

Gender Dysphoria

-

1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy.

-

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

-

Plan Year

-

<b>Prior Authorization Group</b>	TESTOSTERONE ENANTHATE INJ
<b>Drug Names</b>	TESTOSTERONE ENANTHATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Gender Dysphoria
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 4) Requested drug is being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 5) Requested drug is being prescribed for delayed puberty OR 6) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TETRABENAZINE
<b>Drug Names</b>	TETRABENAZINE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For treatment of chorea associated with Huntington's disease: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy. For treatment of tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine or valbenazine therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TETRACYCLINE
<b>Drug Names</b>	TETRACYCLINE HYDROCHLORID
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The patient will use the requested drug orally.
<b>Prior Authorization Group</b>	THALOMID
<b>Drug Names</b>	THALOMID
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, human immunodeficiency virus (HIV)-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TIBSOVO
<b>Drug Names</b>	TIBSOVO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-remission therapy following response to previous lower intensity therapy with the same regimen, OR 3) patient has relapsed or refractory AML.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TOBRAMYCIN
<b>Drug Names</b>	TOBRAMYCIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-cystic fibrosis bronchiectasis
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	TOPICAL LIDOCAINE
<b>Drug Names</b>	GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

<b>Prior Authorization Group</b>	TOPICAL TESTOSTERONES
<b>Drug Names</b>	ANDRODERM, TESTOSTERONE, TESTOSTERONE PUMP
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Gender Dysphoria
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TOPICAL TRETINOIN
<b>Drug Names</b>	AVITA, TRETINOIN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TRAZIMERA
<b>Drug Names</b>	TRAZIMERA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	TRELSTAR
<b>Drug Names</b>	TRELSTAR MIXJECT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TREPROSTINIL INJ
<b>Drug Names</b>	TREPROSTINIL
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.



<b>Prior Authorization Group</b>	TRIENTINE
<b>Drug Names</b>	TRIENTINE HYDROCHLORIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TRIKAFTA
<b>Drug Names</b>	TRIKAFTA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cystic fibrosis (CF): The patient has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor potentiation based on in vitro assay data.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The requested medication will not be used in combination with other medications containing ivacaftor.
<b>Prior Authorization Group</b>	TRUSELTIQ
<b>Drug Names</b>	TRUSELTIQ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

TRUXIMA

TRUXIMA

All FDA-approved Indications, Some Medically-accepted Indications

Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and pemphigus vulgaris

**Exclusion Criteria**

**Required Medical Information**

-

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

-

-

Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year

-

<b>Prior Authorization Group</b>	TUKYSA
<b>Drug Names</b>	TUKYSA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastasis, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TURALIO
<b>Drug Names</b>	TURALIO
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	TYKERB
<b>Drug Names</b>	LAPATINIB DITOSYLATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Metastatic CNS lesions from HER2-positive breast cancer, recurrent EGFR-positive chordoma, HER2-amplified colorectal cancer in combination with trastuzumab.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	TYMLOS
<b>Drug Names</b>	TYMLOS
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
<b>Other Criteria</b>	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.
<b>Prior Authorization Group</b>	UBRELVY
<b>Drug Names</b>	UBRELVY
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has experienced an inadequate treatment response to one triptan 5-HT <sub>1</sub> receptor agonist, OR 2) The patient has experienced an intolerance to one triptan 5-HT <sub>1</sub> receptor agonist, OR 3) The patient has a contraindication that would prohibit a trial of triptan 5-HT <sub>1</sub> receptor agonists.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	UKONIQ
<b>Drug Names</b>	UKONIQ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	V-GO
<b>Drug Names</b>	V-GO 20, V-GO 30, V-GO 40
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has diabetes requiring insulin management with multiple daily injections AND 2) The patient is self-testing glucose levels 4 or more times per day AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For continuation of therapy with an insulin pump, the patient has stable or improved glycemic control.
<b>Prior Authorization Group</b>	VALCHLOR
<b>Drug Names</b>	VALCHLOR
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	VELCADE
<b>Drug Names</b>	BORTEZOMIB, VELCADE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, pediatric acute lymphoblastic leukemia.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	VELTASSA
<b>Drug Names</b>	VELTASSA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has experienced an inadequate treatment response or intolerance to Lokelma OR 2) The patient has a contraindication that would prohibit a trial of Lokelma.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VEMLIDY
<b>Drug Names</b>	VEMLIDY
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For chronic hepatitis B virus infection, the requested drug will be used in a patient who meets either of the following (new starts only): 1) inadequate virologic response, resistance, or intolerable adverse event to tenofovir disoproxil fumarate, OR 2) bone loss and mineralization defects or is at risk for bone loss and mineralization defects (for example, history of fragility fractures, advanced age, frailty, chronic glucocorticoid use, low T-scores, or increased fall risk).

<b>Prior Authorization Group</b>	VENCLEXTA
<b>Drug Names</b>	VENCLEXTA, VENCLEXTA STARTING PACK
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For AML, any of the following criteria must be met: 1) the patient is 60 years of age or older OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy OR 4) the requested drug will be used for relapsed or refractory disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VENTAVIS
<b>Drug Names</b>	VENTAVIS
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	VERSACLOZ
<b>Drug Names</b>	VERSACLOZ
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	VERZENIO
<b>Drug Names</b>	VERZENIO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VIGABATRIN
<b>Drug Names</b>	VIGABATRIN, VIGADRONE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For complex partial seizures (CPS): patient had an inadequate response to at least 2 antiepileptic drugs for CPS.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VITRAKVI
<b>Drug Names</b>	VITRAKVI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	VIZIMPRO
<b>Drug Names</b>	VIZIMPRO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced non-small cell lung cancer (NSCLC)
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC), the patient meets all of the following: 1) the disease is recurrent, advanced or metastatic, and 2) the member has sensitizing EGFR mutation-positive disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VORICONAZOLE
<b>Drug Names</b>	VORICONAZOLE
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	The patient will be using the requested drug orally or intravenously.
<b>Prior Authorization Group</b>	VOSEVI
<b>Drug Names</b>	VOSEVI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C).
<b>Required Medical Information</b>	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD-IDSA guidance.
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	VOTRIENT
<b>Drug Names</b>	VOTRIENT
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, e) extremity/superficial trunk, head/neck sarcoma, f) solitary fibrous tumor or hemangiopericytoma, or g) alveolar soft part sarcoma (ASPS)
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	VRAYLAR
<b>Drug Names</b>	VRAYLAR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	WELIREG
<b>Drug Names</b>	WELIREG
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	XALKORI
<b>Drug Names</b>	XALKORI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, brain metastases from NSCLC, inflammatory myofibroblastic tumors (IMT), anaplastic large cell lymphoma (ALCL)
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC, the requested drug is used in any of the following settings: 1) the member has recurrent, advanced or metastatic ALK-positive NSCLC (including brain metastases from NSCLC), 2) the member has recurrent, advanced or metastatic ROS-1 positive NSCLC (including brain metastases from NSCLC), or 3) the member has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT and ALCL: the disease is ALK-positive.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	XELJANZ
<b>Drug Names</b>	XELJANZ, XELJANZ XR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Inadequate response, intolerance or contraindication to a tumor necrosis factor (TNF) blocker.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	XGEVA
<b>Drug Names</b>	XGEVA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Systemic mastocytosis related osteopenia or osteoporosis
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	XIFAXAN
<b>Drug Names</b>	XIFAXAN
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Reduction in risk of overt HE recurrence: 6 months, IBS-D: 14 days
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	XOLAIR
<b>Drug Names</b>	XOLAIR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
<b>Age Restrictions</b>	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. For nasal polyps: 18 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Allergic asthma and nasal polyps: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	XOSPATA
<b>Drug Names</b>	XOSPATA
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	XPOVIO
<b>Drug Names</b>	XPOVIO, XPOVIO 100 MG ONCE WEEKLY, XPOVIO 40 MG ONCE WEEKLY, XPOVIO 40 MG TWICE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	XTANDI
<b>Drug Names</b>	XTANDI
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	XYREM
<b>Drug Names</b>	XYREM
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) The diagnosis has been confirmed by sleep lab evaluation AND 3) The patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, or methylphenidate) [Note: Coverage of amphetamines and methylphenidates may require prior authorization.] AND 4) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) [Note: coverage of armodafinil may require prior authorization.] OR 5) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy AND 6) The diagnosis has been confirmed by sleep lab evaluation.
<b>Age Restrictions</b>	7 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

<b>Prior Authorization Group</b>	ZARXIO
<b>Drug Names</b>	ZARXIO
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation related indications, neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplant.
<b>Exclusion Criteria</b>	Use of the requested product within 24 hours prior to or following chemotherapy.
<b>Required Medical Information</b>	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patients must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ZEJULA
<b>Drug Names</b>	ZEJULA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	In combination with bevacizumab for persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer for platinum-sensitive disease.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	ZELBORAF
<b>Drug Names</b>	ZELBORAF
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), and colorectal cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cutaneous melanoma, all of the following criteria must be met: 1) tumor is positive for BRAF V600E or V600K mutation, and 2) disease is unresectable or metastatic. For Erdheim-Chester Disease, tumor is positive for BRAF V600E or BRAF V600K mutation. For non-small cell lung cancer all of the following criteria must be met: 1) tumor is positive for the BRAF V600E mutation, and 2) patient has recurrent, advanced, or metastatic NSCLC. For thyroid carcinoma, all the following criteria must be met: 1) tumor is positive for BRAF V600E or V600K mutation, and 2) patient has radioiodine refractory follicular, Hurthle cell, or papillary thyroid carcinoma. For colorectal cancer, all of the following criteria must be met: 1) tumor is BRAF V600E mutation positive, 2) disease is unresectable or metastatic. For hairy cell leukemia: the requested drug will be used for subsequent therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ZIRABEV
<b>Drug Names</b>	ZIRABEV
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, leptomeningeal metastases and metastatic spine tumors, malignant pleural mesothelioma, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, including the following cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, AIDS-related Kaposi sarcoma, uterine cancer, endometrial cancer, vulvar cancer, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity, hepatocellular carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
<b>Prior Authorization Group</b>	ZOLINZA
<b>Drug Names</b>	ZOLINZA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Mycosis fungoides, Sezary syndrome.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ZYDELIG
<b>Drug Names</b>	ZYDELIG
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ZYKADIA
<b>Drug Names</b>	ZYKADIA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic repressor of silencing (ROS-1)-positive non-small cell lung cancer (NSCLC), inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC: the member has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the member has ALK-positive NSCLC
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ZYPREXA RELPREVV
<b>Drug Names</b>	ZYPREXA RELPREVV
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Tolerability with oral olanzapine has been established.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# Notice of Non-Discrimination

## In Compliance with Section 1557 of the Affordable Care Act



Health Choice Pathway (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Choice Pathway does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Choice Pathway:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact:

Health Choice Pathway  
**Address:** 410 N. 44th Street, Ste. 900  
Phoenix, AZ 85008  
**Phone:** 1-800-656-8991  
**Fax:** 480-760-4739  
**TTY:** 711  
**Email:** [HCH.GrievanceForms@HealthChoiceAZ.com](mailto:HCH.GrievanceForms@HealthChoiceAZ.com)

If you believe that Health Choice Pathway has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email to:

Health Choice Pathway  
**Address:** 410 N. 44th Street, Ste. 900  
Phoenix, AZ 85008  
**Phone:** 1-800-656-8991  
**Fax:** 480-760-4739  
**TTY:** 711  
**Email:** [HCH.GrievanceForms@HealthChoiceAZ.com](mailto:HCH.GrievanceForms@HealthChoiceAZ.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Grievance Manager/Civil Rights Coordinator is available to help you.

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

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

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

Health Choice Pathway is an affiliate of Blue Cross® Blue Shield® of Arizona.

# Aviso de No Discriminación

**En cumplimiento con la Sección 1557  
de la Ley de Cuidado de Salud de Bajo Costo**



Health Choice Pathway (HMO D-SNP) cumple con las leyes de derechos civiles federales vigentes y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health Choice Pathway no excluye a las personas ni las trata de manera diferente por su raza, color, nacionalidad, edad, discapacidad o sexo.

Health Choice Pathway:

Ofrece material de ayuda y servicios sin cargo a las personas que tienen discapacidades que les impiden comunicarse de manera eficaz con nosotros, como los siguientes:

- Intérpretes de lenguaje de señas calificados
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Brinda servicios de idiomas sin cargo a las personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con nosotros:

Health Choice Pathway  
**Dirección:** 410 N. 44th Street, Ste. 900  
Phoenix, AZ 85008  
**Teléfono:** 1-800-656-8991  
**Fax:** 480-760-4739  
**TTY:** 711  
**Correo electrónico:**  
**HCH.GrievanceForms@HealthChoiceAZ.com**

Si considera que Health Choice Pathway no ha logrado prestar estos servicios o ha discriminado de algún otro modo a una persona por su raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal por correo, fax o correo electrónico:

Health Choice Pathway  
**Dirección:** 410 N. 44th Street, Ste. 900  
Phoenix, AZ 85008  
**Teléfono:** 1-800-656-8991  
**Fax:** 480-760-4739  
**TTY:** 711  
**Correo electrónico:**  
**HCH.GrievanceForms@HealthChoiceAZ.com**

Puede presentar una queja formal personalmente o por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja formal, el administrador de quejas formales/coordinador de derechos civiles está a su disposición para ayudarlo.

También puede presentar una queja por violación a los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de forma electrónica a través de su Portal de quejas, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono:

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

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

Health Choice Pathway es una afiliada de Blue Cross® Blue Shield® of Arizona.

# Multi-Language Interpreter Services



as required by Section 1557 of the Affordable Care Act

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-656-8991 (TTY: 711)**, 8 a.m. – 8 p.m., 7 days a week.

ATENCIÓN: si usted habla español, tiene a su disposición servicios de asistencia lingüística sin cargo. Llame al **1-800-656-8991 (TTY: 711)**.

注意：日本語を話される場合、無料で言語支援サービスをご利用いただけます。次の番号までお電話してください：**1-800-656-8991 (TTY: 711)**

Bilagáana bizaad doo bee yánílti' dago dóo saad nááná ła' bee yánílti'go, saad bee ata' hane', t'áa níík'eh, ná bee ahóót'i'. Koji' hodílnih **1-800-656-8991 (TTY: 711)**.

ATENÇÃO: se você fala português brasileiro, oferecemos serviços gratuitos de assistência para idiomas. Ligue para **1-800-656-8991 (TDD: 711)**.

CHÚ Ý: Nếu quý vị nói [Tiếng Việt], chúng tôi sẽ cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi số **1-800-656-8991 (TTY: 711)**.

تنبيه: إذا كنت تتحدث العربية، فسوف تتوفر لديك خدمات المساعدة اللغوية، مجاناً. اتصل على **1-800-656-8991 (هاتف نصي: 711)**.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-656-8991 (TTY: 711)**.

ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang, gratis, disponib pou ou. Rele **1-800-656-8991 (TTY: 711)**.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Fremdsprachenservice zur Verfügung. Rufen Sie **1-800-656-8991 (TTY: 711)** an.

ΠΡΟΣΟΧΗ: εάν μιλάτε Ελληνικά, μπορείτε να λάβετε δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό **1-800-656-8991 (TTY: 711)**.

સૂચના: જો તમે બોલતા હોવ, તો તમારા માટે મફત ભાષા સહાયતા સેવાઓ ઉપલબ્ધ છે. સંપર્ક **1-800-656-8991 (TTY: 711)**.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नःशुल्क उपलब्ध हैं। **1-800-656-8991 (TTY: 711)** पर कॉल करें।

# Multi-Language Interpreter Services



as required by Section 1557 of the Affordable Care Act

**ATTENZIONE:** se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiami il numero **1-800-656-8991 (TTY: 711)**.

請注意：若您使用繁體中文，您可以接受免費的語言協助服務。請致電 **1-800-656-8991 (TTY: 711)**。

주의: 한국어를 사용하는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-800-656-8991 (TTY: 711)** 번으로 전화하십시오.

โปรดทราบ: หากคุณพูดภาษาไทย คุณจะสามารถใช้บริการความช่วยเหลือด้านภาษาได้โดยไม่มีค่าใช้จ่าย โทร **1-800-656-8991 (TTY: 711)**

**FAKATOKANGA'I:** Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1-800-656-8991 (TTY: 711)**.

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើលោកអ្នកនិយាយភាសា ខ្មែរ យើងខ្ញុំមានសេវាកម្មជំនួយភាសាដល់លោកអ្នកដោយមិនគិតថ្លៃនោះទេ។ សូមហៅទូរសព្ទមកលេខ **1-800-656-8991 (TTY: 711)**។

**UWAGA:** Jeżeli mówi Pan/Pani po polsku, oferujemy bezpłatne usługi pomocy językowej. Prosimy o kontakt pod numerem **1-800-656-8991 (telefon tekstowy (TTY): 711)**.

**PAŽNJA:** Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su Vam besplatno. Pozovite **1-800-656-8991 (TTY: 711)**.

**ATENSIYON:** Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, na walang singil, ay magagamit mo. Tumawag sa **1-800-656-8991 (TTY: 711)**.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی رایگان به شما ارائه می‌شود. **1-800-656-8991 (TTY: 711)**. تماس بگیرید.

مَعْبَرَةٌ: اَيْنَ بَعَالَتُكَ دَمَخَةٌ (لَسْنَا اُسُورِيًّا) وَبِمَجَن دَلَا اَجْرًا بَنِيْنَا دَعْمِشَةً وَعَدَرْنَةً. **1-800-656-8991 (TTY: 711)** عُبُودُ شَقْلِيْبَلَةً بَنَن مَنِيْنَا.