Products Affected

- COMETRIQ CAP 100MG DAILY DOSE CARTON PACK (New Starts O
- COMETRIQ CAP 140MG DAILY DOSE CARTON PACK (New Starts O
- COMETRIQ CAP 60MG DAILY DOSE CARTON PACK (New Starts On

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

Products Affected

- COPIKTRA 15MG CAP (New Starts Only)
- COPIKTRA 25MG CAP (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For adults (18 years and older), one of the following: A) Member is on a maximally tolerated dose of beta blocker OR B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiology specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- COTELLIC 20MG TAB (New Starts Only)

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

Products Affected

- CYSTADROPS 0.37% OPHTH SOLN

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

Products Affected

- CYSTARAN 0.44% OPHTH SOLN

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

Products Affected

- *roflumilast 250mcg tab*
- *roflumilast 500mcg tab*

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

Products Affected

- DAURISMO 100MG TAB (New Starts Only)
- DAURISMO 25MG TAB (New Starts Only)

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

Products Affected

- DIACOMIT 250MG CAP (New Starts Only)
- DIACOMIT 500MG CAP (New Starts Only)
- DIACOMIT 250MG POWDER FOR ORAL SUSP (New Starts Only)
- DIACOMIT 500MG POWDER FOR ORAL SUSP (New Starts Only)

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

Products Affected

- DIFICID 200MG TAB
- DIFICID 40MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of, intolerance, or contraindication to generic vancomycin capsules.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

Products Affected

- DOPTELET 20MG TAB
- DOPTELET TAB 40MG DAILY DOSE PACK
- DOPTELET TAB 60MG DAILY DOSE PACK

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

Products Affected

- DAYVIGO 10MG TAB
- DAYVIGO 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of two of the following: a) eszopiclone, b) ramelteon, c) zaleplon, or d) zolpidem.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *dronabinol 10mg cap*
- *dronabinol 2.5mg cap*
- *dronabinol 5mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Products Affected

- DUPIXENT 100MG/0.67ML SYRINGE
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML SYRINGE
- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Intolerance to, or failure of therapy of both of the following: a) an oral corticosteroid AND b) a nasal corticosteroid. For eosinophilic esophagitis: Trial of a topical corticosteroid was ineffective, not tolerated, or contraindicated. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of Dupixent.
Age Restrictions	For Atopic Dermatitis: Member must be 6 months of age or older. For Asthma: Member must be 6 years of age or older. For Nasal polyps: Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergist, gastroenterologist, immunologist, pulmonologist, dermatologist or ENT specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	For initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: Member has one of the following: 1) moderate to severe asthma with an eosinophilic phenotype (baseline blood eosinophil concentration is provided and is greater than or equal to 150 cells/mL) OR 2) member has oral corticosteroid-dependent asthma. For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia).

Products Affected

- EMGALITY 100MG/ML SYRINGE
- EMGALITY 120MG/ML SYRINGE
- EMGALITY 120MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) Member has tried and failed an 8-week or greater trial of 2 of the 3 following drug classes: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis: Member has tried and failed verapamil. For continuation requests (all diagnoses): Prescriber attests to improvement in the member's condition with use of Emgality.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ENBREL 25MG/0.5ML INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML AUTO-INJECTOR
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine.
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ENDARI 5GM POWDER FOR ORAL SOLN

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

Products Affected

- ENSPRYNG 120MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a positive test for anti-aquaporin-4 antibodies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, ophthalmologist, or neuro-ophthalmologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Will not be used in combination with eculizumab (Soliris) or inebilizumab (Uplinza).

Products Affected

- SOFOSBUVIR 400MG/VELPATASVIR 100MG TAB

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

Products Affected

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

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

Products Affected

- EPOGEN 10000UNIT/ML INJ
- EPOGEN 20000UNIT/ML INJ
- EPOGEN 2000UNIT/ML INJ
- EPOGEN 3000UNIT/ML INJ
- EPOGEN 4000UNIT/ML INJ

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

Products Affected

- ERIVEDGE 150MG CAP (New Starts Only)

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

Products Affected

- ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-sensitive prostate cancer (mCSPC): failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC): no prior agent trial required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ESBRIET 267MG CAP
- ESBRIET 267MG TAB
- ESBRIET 801MG TAB
- *pirfenidone 267mg tab*
- *pirfenidone 801mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography indicates definite UIP pattern 3) Both High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- EVRYSDI 0.75MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Will not be used in combination with nusinersen (Spinraza).

Products Affected

- EXKIVITY 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of EGFR exon 20 insertion mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- FASENRA 30MG/ML AUTO-INJECTOR
- FASENRA 30MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Peripheral blood eosinophil count is provided and greater than or equal to 150 cells per microliter. B) History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For continuation requests: Documentation is provided of positive clinical response.
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with, an allergy specialist, immunologist, or pulmonary specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *deferiprone 1000mg tab*
- FERRIPROX 1000MG TAB
- *deferiprone 500mg tab*
- FERRIPROX 100MG/ML ORAL SOLN

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

Products Affected

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

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

Products Affected

- FIRDAPSE 10MG TAB

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

Products Affected

- FIRMAGON 120MG/VIAL INJ (New Starts Only)
- FIRMAGON 80MG INJ (New Starts Only)

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

Products Affected

- DICLOFENAC EPOLAMINE 1.3% PATCH
- FLECTOR 1.3% PATCH

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

Products Affected

- FOTIVDA 0.89MG CAP (New Starts Only)
- FOTIVDA 1.34MG CAP (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For partial-onset seizures: Member tried and failed both of the following: a) topiramate AND b) Vimpat (lacosamide). For primary generalized tonic-clonic seizures: Member tried and failed two of the following: a) lamotrigine, b) levetiracetam, c) primidone OR d) topiramate.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or epilepsy specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- GALAFOLD 28 DAY WALLET 123MG PACK

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

Products Affected

- GARDASIL 9 INJ
- GARDASIL 9 SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-45.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- GATTEX 5MG INJ

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

Products Affected

- GAVRETO 100MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- *glatiramer acetate 20mg/ml syringe*
- *glatopa 20mg/ml syringe*
- *glatiramer acetate 40mg/ml syringe*
- *glatopa 40mg/ml syringe*

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

Products Affected

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

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

Products Affected

- BERINERT 500UNIT INJ
- HAEGARDA 2000UNIT INJ
- *icatibant 10mg/ml syringe*
- *sajazir 30mg/3ml syringe*
- TAKHZYRO 300MG/2ML SYRINGE
- CINRYZE 500UNIT INJ
- HAEGARDA 3000UNIT INJ
- RUCONEST 2100UNIT INJ
- TAKHZYRO 300MG/2ML INJ

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

Products Affected

- HETLIOZ 20MG CAP
- HETLIOZ 4MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For non-24-hour sleep-wake disorder: Member is totally blind. For Smith-Magenis syndrome: Diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or sleep specialist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) One of the following: i) Untreated LDL greater than 500 mg/dL OR ii) treated LDL greater than or equal to 300 mg/dL. B) Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (dates and reasons for discontinuation are provided). For patients with statin intolerance, concurrent use of maximum statin dose not required. C) Documentation is provided showing the most recent full lipid panel, including Apo-B, from within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a lipidologist, cardiologist, or an endocrinologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe Rheumatoid Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 20mg/week required (or maximally tolerated dose). For Juvenile Idiopathic Arthritis: Failure of, or intolerance to therapy with, methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose). For Plaque Psoriasis: Failure of, or intolerance to therapy with one of the following: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) soriatane. For Ankylosing Spondylitis (AS): Failure of, or intolerance to sulfasalazine (Trial of sulfasalazine not required for AS with predominant axial involvement). For Psoriatic Arthritis: Failure of, or intolerance to one of the following: a) methothrexate OR b) sulfasalazine. For Ulcerative Colitis or Crohn's Disease: Failure of, or intolerance to one of the following: a) corticosteroid, b) azathioprine, c) methotrexate OR d) 6-mercaptopurine. For Hidradenitis Suppurativa (HS): Member must have both of the following: a) At least 3 cysts AND b) failure of therapy with at least one (1) oral antibiotic. For Uveitis: Failure of, or intolerance to, therapy with both of the following: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine).
Age Restrictions	
Prescriber Restriction	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS): Prescribed by, or in consultation with, a dermatology specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with, a gastroenterology specialist. For Uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.
Coverage Duration	Approved for duration of contract year.

Products Affected

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

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

Products Affected

- ICLUSIG 10MG TAB (New Starts Only)
- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 30MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

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

Products Affected

- IDHIFA 100MG TAB (New Starts Only)
- IDHIFA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH2 mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- ABILIFY 300MG INJ (New Starts Only)
- ABILIFY 400MG INJ (New Starts Only)
- ARISTADA 1064MG/3.9ML SYRINGE (New Starts Only)
- ARISTADA 662MG/2.4ML SYRINGE (New Starts Only)
- ARISTADA 882MG/3.2ML SYRINGE (New Starts Only)
- INVEGA 117MG/0.75ML SYRINGE (New Starts Only)
- INVEGA 156MG/ML SYRINGE (New Starts Only)
- INVEGA 273MG/0.875ML SYRINGE (New Starts Only)
- INVEGA 410MG/1.315ML SYRINGE (New Starts Only)
- INVEGA 78MG/0.5ML SYRINGE (New Starts Only)
- RISPERDAL 12.5MG INJ (New Starts Only)
- RISPERDAL 37.5MG INJ (New Starts Only)
- ABILIFY 300MG SYRINGE (New Starts Only)
- ABILIFY 400MG SYRINGE (New Starts Only)
- ARISTADA 441MG/1.6ML SYRINGE (New Starts Only)
- ARISTADA 675MG/2.4ML SYRINGE (New Starts Only)
- INVEGA 1092MG/3.5ML SYRINGE (New Starts Only)
- INVEGA 1560MG/5ML SYRINGE (New Starts Only)
- INVEGA 234MG/1.5ML SYRINGE (New Starts Only)
- INVEGA 39MG/0.25ML SYRINGE (New Starts Only)
- INVEGA 546MG/1.75ML SYRINGE (New Starts Only)
- INVEGA 819MG/2.625ML SYRINGE (New Starts Only)
- RISPERDAL 25MG INJ (New Starts Only)
- RISPERDAL 50MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has established tolerability with the oral version of medication being requested.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- IMPAVIDO 50MG CAP

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

Products Affected

- INCRELEX 40MG/4ML INJ

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

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 60MG CAP
- INGREZZA 80MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy B) Member has a functional disability due to tardive dyskinesia.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- INLYTA 1MG TAB (New Starts Only)
- INLYTA 5MG TAB (New Starts Only)

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

Products Affected

- INQOVI 5 TABLET PACK (New Starts Only)

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

Products Affected

- INREBIC 100MG CAP (New Starts Only)

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

Products Affected

- IRESSA 250MG TAB (New Starts Only)

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

Products Affected

- ISTURISA 10MG TAB
- ISTURISA 1MG TAB
- ISTURISA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation requests: Documentation is provided of urinary cortisol levels that show a positive clinical response.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *itraconazole 10mg/ml oral soln*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB

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

Products Affected

- KEVZARA 150MG/1.14ML AUTO-INJECTOR
- KEVZARA 200MG/1.14ML AUTO-INJECTOR
- KEVZARA 150MG/1.14ML SYRINGE
- KEVZARA 200MG/1.14ML SYRINGE

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Ibrance.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- KORLYM 300MG TAB

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

Products Affected

- KOSELUGO 10MG CAP (New Starts Only)
- KOSELUGO 25MG CAP (New Starts Only)

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

Products Affected

- *javygtor 100mg powder for oral soln*
- *sapropterin 100mg tab*
- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Documentation is provided of disease improvement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for duration of contract year.
Other Criteria	

Products Affected

- KYNMOBI 10MG SUBLINGUAL FILM
- KYNMOBI 15MG SUBLINGUAL FILM
- KYNMOBI 20MG SUBLINGUAL FILM
- KYNMOBI 25MG SUBLINGUAL FILM
- KYNMOBI 30MG SUBLINGUAL FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failed levodopa/carbidopa adjunctive therapy in combination with both of the following: a) rasagiline AND b) entacapone.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- *ambrisentan 10mg tab*
- *ambrisentan 5mg tab*

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

Products Affected

- *lidocaine 5% patch*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *lidocaine 5% ointment*

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

Products Affected

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

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

Products Affected

- LIVMARLI 9.5MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Documentation is provided of a mutation in one of the following: a) JAG1 gene OR b) NOTCH2 gene. For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist, gastroenterologist, or provider that specializes in the treatment of Alagille syndrome.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- LIVTENCITY 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescriber attests that the medication will not be used for CMV infection prophylaxis.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 3 months.
Other Criteria	

Products Affected

- LOKELMA 10GM POWDER FOR ORAL SUSP
- LOKELMA 5GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has baseline persistent potassium level greater than 5.0 mmol/L.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- LONSURF 6.14-15MG TAB (New Starts Only)
- LONSURF 8.19-20MG TAB (New Starts Only)

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

Products Affected

- LORBRENA 100MG TAB (New Starts Only)
- LORBRENA 25MG TAB (New Starts Only)

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

Products Affected

- LUCEMYRA 0.18MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has failure of, or intolerance to, clonidine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a prescriber specializing in pain management or addiction treatment.
Coverage Duration	Approved for 1 month.
Other Criteria	If member was initiated on lofexidine at an inpatient facility and request is for continuing therapy for up to a total of 14 days, prescriber and medical restrictions not required.

Products Affected

- LUMAKRAS 120MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of KRAS G12C mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- LUPKYNIS 7.9MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation therapy: Documentation is provided of disease improvement.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	Will not be used in combination with belimumab (Benlysta).

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- MEKTOVI 15MG TAB (New Starts Only)

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

Products Affected

- METHITEST 10MG TAB
- METHYLTESTOSTERONE 10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For hypogonadism: Documentation is provided of morning testosterone levels, from two separate days, fall below the normal range for a healthy adult male. B) For patients already on testosterone replacement therapy, documentation is provided of at least one morning testosterone level from the last 12 months is required. C) For sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal: testosterone levels are not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

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

Products Affected

- MOTEGRITY 1MG TAB
- MOTEGRITY 2MG TAB

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

Products Affected

- MOUNJARO 10MG/0.5ML AUTO-INJECTOR
- MOUNJARO 15MG/0.5ML AUTO-INJECTOR
- MOUNJARO 5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 12.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 2.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 7.5MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of both of the following was ineffective, contraindicated, or not tolerated: A) Trulicity AND B) Ozempic.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

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

Products Affected

- MYFEMBREE 1-0.5-40MG TAB

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

Products Affected

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

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

- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 0.5mg tab*
- *sirolimus 1mg tab*
- *sirolimus 1mg/ml oral soln*
- *sirolimus 2mg tab*
- *tacrolimus 0.5mg cap*
- *tacrolimus 1mg cap*
- *tacrolimus 5mg cap*
- TDVAX 4-4UNIT/ML INJ
- TENIVAC 4-10UNIT/ML INJ
- TENIVAC 4-10UNIT/ML SYRINGE
- TPN ELECTROLYTES INJ
- TRAVASOL 10% INJ
- TROPHAMINE 10% INJ
- VARUBI 90MG TAB
- ZORTRESS 1MG TAB

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

Products Affected

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

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

Products Affected

- NERLYNX 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- NOURIANZ 20MG TAB
- NOURIANZ 40MG TAB

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

Products Affected

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

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

Products Affected

- NUBEQA 300MG TAB (New Starts Only)

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

Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML SYRINGE
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 40MG/0.4ML SYRINGE

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

Products Affected

- NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided (in the form of chart notes or imaging) of a structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	Approved for duration of contract year.
Other Criteria	

Products Affected

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

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

Products Affected

- NURTEC 75MG ODT

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

Products Affected

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

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

Products Affected

- NUZYRA 150MG TAB

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

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

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

Products Affected

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

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

Products Affected

- ODOMZO 200MG CAP (New Starts Only)

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

Products Affected

- OFEV 100MG CAP
- OFEV 150MG CAP

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

Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB

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

Products Affected

- ONGENTYS 25MG CAP
- ONGENTYS 50MG CAP

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

Products Affected

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

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

Products Affected

- OPSUMIT 10MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- ORGOVYX 120MG TAB (New Starts Only)

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

Products Affected

- ORIAHNN 28 DAY KIT PACK

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

Products Affected

- ORILISSA 150MG TAB
- ORILISSA 200MG TAB

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

Products Affected

- WAKIX 17.8MG TAB
- WAKIX 4.45MG TAB

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

Products Affected

- WELIREG 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- XATMEP 2.5MG/ML ORAL SOLN

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

Products Affected

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

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

Products Affected

- XENLETA 600MG TAB

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

Products Affected

- XERMELO 250MG TAB

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

Products Affected

- XGEVA 120MG/1.7ML INJ

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

Products Affected

- XIFAXAN 200MG TAB

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

Products Affected

- XIFAXAN 550MG TAB

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

Products Affected

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

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

Products Affected

- XOSPATA 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- XULTOPHY 100UNIT-3.6MG/ML PEN INJ

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

Products Affected

- XYREM 500MG/ML ORAL SOLN

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

Products Affected

- *miglustat 100mg cap*

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

Products Affected

- ZEJULA 100MG CAP (New Starts Only)

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

Products Affected

- ZELBORAF 240MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- ZOLINZA 100MG CAP (New Starts Only)

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

Products Affected

- ZONTIVITY 2.08MG TAB

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

Products Affected

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

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

Products Affected

- ZYKADIA 150MG TAB (New Starts Only)

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