ACTIMMUNE

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Hypersensitivity to Actimmune or E. coli derived products

REQUIRED MEDICAL INFORMATION
1. Dx chronic granulomatous disease OR Dx severe malignant osteopetrosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvD

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AKEEGA

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC)
   a. Reason of medical necessity or contraindication/intolerance to the use of olaparib (Lynparza)
2. Dx of deleterious or suspected deleterious BRCA2-mutated (BRCAm) metastatic castration-sensitive prostate cancer (mCSPC)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALECENSA

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of NSCLC that is ALK-positive a. Tumors are anaplastic lymphoma kinase (ALK)-positive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALUNBRIG

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)Dx of metastatic non-small cell lung cancer (NSCLC) a)Tumors are anaplastic lymphoma kinase (ALK)-positive 2)Reason of medical necessity or contraindication/intolerance to the use of alectinib (Alecensa)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALZHEIMERS MAB

MEDICATION(S)

LEQEMBI IQLIK, LEQEMBI IQLIK (500 MG DOSE)

PENDING CMS APPROVAL

AMBRISENTAN

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of PAH

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

APO B

MEDICATION(S)

JUXTAPID

PENDING CMS APPROVAL

AQNEURSA

MEDICATION(S)
AQNEURSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Use in combination with Miplyffa

REQUIRED MEDICAL INFORMATION
1. Pt has tried and failed at least 3 months of therapy with miglustat as evidenced by a lack of improvement in disease progression (e.g. horizontal saccadic eye movements, SARA scale, R4DNPCCSS score) 2. Pt weighs greater than or equal to 15kg 3. Dx is genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2 OR if there is a mutation in only one allele of NPC1 or NPC2, pt has positive filipin staining or elevated cholestane triol/oxysterols (greater than 2x upper limit of normal) 4. Pt is presenting with at least one neurological symptom of the disease (for example, but not limited to, hearing loss, vertical supranuclear gaze paly, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia) 5. Pt is able to walk either independently or with assistance 6. Pt has a SARA score of greater than or equal to 7 and less than or equal to 34 points (out of 40) AND one of the following: A. Within in 2-7 range (0-8 range) of the Gait subtest of the SARA scale B. Be able to perform the 9-Hole Peg Test with Dominant Hand ((HPT-D) (SCAFI subtest) in greater than or equal to 20 to less than or equal to 150 seconds 7. Reauthorization A. fSARA score has remained stable/improved

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
6 months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ARCALYST

MEDICATION(S)

ARCALYST

PENDING CMS APPROVAL

ATOPIC DERM

MEDICATION(S)

ADBRY

PENDING CMS APPROVAL

AUGTYRO

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC) or NTRK gene fusion-positive solid tumors a. Reason of medical necessity or contraindication/intolerance to the use of entrectinib (Rozlytrek)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of chorea associated with Huntington's disease 2. Dx of tardive dyskinesia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AVMAPKI FAKZYNJA

MEDICATION(S)
AVMAPKI FAKZYNJA CO-PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of recurrent KRAS-mutated, recurrent low-grade serous ovarian cancer
2. Prior therapy including platinum-based therapy
3. Patient has been treated with trametinib (Mekinist) or documented medical rationale has been provided explaining why it would be inappropriate treatment for the patient

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AYVAKIT

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)Diagnosis of: a)Unresectable or metastatic GIST that is platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation positive including PDGFRA D842V mutations. b)Advanced Systemic Mastocytosis: AdvSM includes patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL). c)Indolent Systemic Mastocytosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZTREONAM

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has had at least ONE positive culture for Pseudomonas aeruginosa 2. Previous trial on generic tobramycin

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BALVERSA

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of locally advanced or metastatic urothelial carcinoma 2. Confirmed fibroblast growth factor receptor (FGFR3) genetic alteration 3. Progression on or after at least one line of prior systemic therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BENLYSTA

MEDICATION(S)

BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

PENDING CMS APPROVAL

BESREMI

MEDICATION(S)

BESREMI, BESREMI PEN

PENDING CMS APPROVAL

BINIMETINIB

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of BRAF V600E or V600K mutation-positive unresectable or metastatic melanoma: a. Will be used in combination therapy with encorafenib 2. Diagnosis of BRAF V600E mutation-positive metastatic non-small cell lung cancer (NSCLC): a. Will be used in combination therapy with encorafenib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSENTAN

MEDICATION(S)
BOSENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of PAH

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSULIF

MEDICATION(S)
BOSULIF 100 MG CAP, BOSULIF 100 MG TAB, BOSULIF 500 MG TAB, BOSULIF 50 MG CAP, BOSUTINIB 400 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt is diagnosed with Philadelphia chromosome positive (Ph+) CML
   a. Pt has previous failure or intolerance to dasatinib
   b. Pt's CML is newly diagnosed in chronic phase
   c. Pt's CML is in chronic phase, accelerated phase, or blast phase,
2. For CML in chronic phase, accelerated phase, or blast phase:
   a. Pt has previous failure or intolerance to dasatinib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

BRAFTOVI

MEDICATION(S)

BRAFTOVI

PENDING CMS APPROVAL

BRONCHITOL

MEDICATION(S)

BRONCHITOL, BRONCHITOL TOLERANCE TEST

PENDING CMS APPROVAL

BRUKINSA

MEDICATION(S)

BRUKINSA 160 MG TAB

PENDING CMS APPROVAL

BYSANTI

MEDICATION(S)

BYSANTI, BYSANTI TITRATION PACK A, BYSANTI TITRATION PACK B, BYSANTI TITRATION PACK C

PENDING CMS APPROVAL

CABLIVI

MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) 2. Started inpatient in combination with plasma exchange B.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Max Duration of therapy 58 days following last day of plasma exchange

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CABOMETYX

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of hepatocellular carcinoma a. Previous use of sorafenib 2. Dx of advanced renal cell carcinoma 3. Dx of locally advanced or metastatic differentiated thyroid cancer (DTC) a. progression following prior VEGFR-targeted therapy b. patient is radioactive iodine-refractor or ineligible 4. Dx of previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET) a. For adult patients, pt has failed everolimus or sunitinib 5. Dx of previously treated, unresectable, locally advanced or metastatic, well-differentiated extra-pancreatic neuroendocrine tumors (epNET)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

CALQUENCE

MEDICATION(S)

CALQUENCE 100 MG TAB

PENDING CMS APPROVAL

CAPLYTA

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Major Depressive Disorder (MDD): Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CAPRELSA

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARBAGLU

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of hyperammonemia due to N-acetylglutamate synthase deficiency

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CHOLBAM

MEDICATION(S)
CHOLBAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial: a. Pt has abnormal results from a urinary bile acids analysis by mass spectrometry and neurologic exam, 2. Reauth: a. Patient has experienced improvement in ALT/AST values, bilirubin values, and/or weight

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: Plan year Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COBENFY

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Schizophrenia: Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

COBIMETINIB

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of BRAF V600E or V600K mutation-positive unresectable or metastatic melanoma: a. In combination with vemurafenib 2. A diagnosis of histiocytic neoplasms: a. Used as a single agent

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COMETRIQ

MEDICATION(S)
COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of a. Progressive, metastatic medullary thyroid cancer (MMTC)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COPIKTRA

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Previous use of 2 prior therapies for indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COSENTYX

MEDICATION(S)

COSENTYX 150 MG/ML SOLN PRSYR, COSENTYX 75 MG/0.5ML SOLN PRSYR, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

PENDING CMS APPROVAL

CRESEMBA

MEDICATION(S)
CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Prophylaxis for Invasive fungal infection, Hematological malignancy and hemopoietic stem cell transplantation

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has confirmed fungal infection with one of the following:
   a. Invasive aspergillosis
   b. Invasive mucormycosis
2. OR, Cresemba is being used for prophylaxis against invasive fungal infections in the setting of hematological malignancy or hematopoietic cell transplant
   a. When used for prophylaxis, ONE of the following must be met:
      i. Patient has tried and failed a generic antifungal (fluconazole, posaconazole, voriconazole), OR
      ii. Patient has a contraindication to other antifungals due to QTc prolongation or drug-drug interactions

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious disease specialist

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

CRINONE

MEDICATION(S)
CRINONE 4 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A. Diagnosis of secondary amenorrhea

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTAGON

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of nephropathic cystinosis 2. Elevated baseline WBC cysteine levels 2. CTNS gene mutation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DANZITEN

MEDICATION(S)

DANZITEN

PENDING CMS APPROVAL

DARAXONRASIB

MEDICATION(S)

RASONQUE

PENDING CMS APPROVAL

DAURISMO

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Equal to or greater than 75 years or has comorbidity preventing use of intensive induction chemotherapy. 2. Be given in combination with low-dose cytarabine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DIACOMIT

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Dravet syndrome 2. Previous use of clobazam and valproic acid 3. To be used in combination with clobazam

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DRONABINOL

MEDICATION(S)
DRONABINOL 10 MG CAP, DRONABINOL 2.5 MG CAP, DRONABINOL 5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For HIV-associated wasting syndrome OR cancer-associated anorexia dx: a. Pt has previous trial on megestrol, 2. For CINV dx: a. Pt has previous trial on olanzapine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvD determination

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DULAGLUTIDE

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Type 1 diabetes mellitus

REQUIRED MEDICAL INFORMATION
Diagnosis of Type 2 diabetes mellitus (T2DM)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DUPIXENT

MEDICATION(S)

DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

PENDING CMS APPROVAL

ENBREL

MEDICATION(S)

ENBREL 25 MG/0.5ML SOLN PRSYR, ENBREL 25 MG/0.5ML SOLUTION, ENBREL 50 MG/ML SOLN PRSYR, ENBREL MINI, ENBREL SURECLICK

PENDING CMS APPROVAL

ENDARI

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Renal insufficiency, 2. Uncontrolled liver disease

REQUIRED MEDICAL INFORMATION
1. Dx of Sickle Cell Disease (SCD), 2. Tx to prevent acute complications of sickle cell disease, 3. Previous use, concurrent use, or inability to use generic hydroxyurea, 4. Reauthorization: reduction in the number of acute complications (i.e blood transfusions, sickle cell crisis, hospitalizations) of sickle cell disease since initiating therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENSACOVE

MEDICATION(S)
ENSACOVE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. A diagnosis of metastatic non-small cell lung cancer (NSCLC)
   A. tumors are anaplastic lymphoma kinase (ALK)-positive
   B. Provider has supplied a rationale to support why Alecensa cannot be used as first line therapy for metastatic NSCLC
2. A diagnosis of locally advanced non-small cell lung cancer (NSCLC)
   A. tumors are anaplastic lymphoma kinase (ALK)-positive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ENSPRYNG

MEDICATION(S)

ENSPRYNG

PENDING CMS APPROVAL

ENTYVIO SQ

MEDICATION(S)
ENTYVIO PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Combination therapy with another biologic medication, JAK Inhibitor, or Otezla

REQUIRED MEDICAL INFORMATION
1. Diagnosis of:
    a. moderate to severe Crohn's disease
    b. moderate to severe Ulcerative Colitis (UC)
2. For SQ, is patient established on Entyvio IV and changing to Entyvio SQ

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

EPCLUSA

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Chart notes documenting genotype,

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 Weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EPIDIOLEX

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Previous use of two alternative antiepileptic medications and used in combination with another antiepileptic

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERIVEDGE

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has recurring lesions after radiation therapy OR radiation therapy is contraindicated or inappropriate, 2. Pt has recurring lesions after surgical excision OR surgery is contraindicated or inappropriate

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERLEADA

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)Diagnosis of metastatic castration sensitive prostate cancer (mCSPC) a)Patient has tried and failed abiraterone 250mg tablets AND Xtandi 2)Diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC) a)Patient has PSA doubling time of less than 10 months b)Patient has failed Xtandi

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ESBRIET

MEDICATION(S)

PIRFENIDONE

PENDING CMS APPROVAL

ETHACRYNIC ACID

MEDICATION(S)
ETHACRYNIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt needs diuresis for any of the following: a. Edema associated with congestive heart failure, b. Edema associated with cirrhosis of the liver, c. Edema associates with renal disease. d. Short-term management of ascites due to malignancy, idiopathic edema, or lymphedema. 2. Pt has previous trial and failure on a loop diuretic or thiazide diuretic

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ETRASIMOD

MEDICATION(S)

VELSIPITY

PENDING CMS APPROVAL

EULEXIN

MEDICATION(S)
EULEXIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1.Severe hepatic impairment

REQUIRED MEDICAL INFORMATION
1. Diagnosis of:
   a. Locally confined Stage B2-C carcinoma of the prostate
   b. Stage D2 metastatic carcinoma of the prostate
2. Will be used in combination with LHRH-agonist

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVENITY

MEDICATION(S)

EVENITY

PENDING CMS APPROVAL

FANAPT

MEDICATION(S)
FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Bipolar 1 Disorder or Schizophrenia: Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FARESTON

MEDICATION(S)
TOREMIFENE CITRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Pt has congenital or acquired QT prolongation, 2. Pt has uncorrected hypokalemia, 3. Pt has uncorrected hypomagnesemia

REQUIRED MEDICAL INFORMATION
1. A diagnosis of metastatic breast cancer
2. Reason of medical necessity or contraindication/intolerance to the use of tamoxifen therapy
3. Pt has previous trial and failure or contraindication to aromatase inhibitor therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FASENRA

MEDICATION(S)

FASENRA, FASENRA PEN

PENDING CMS APPROVAL

FILSPARI

MEDICATION(S)

FILSPARI

PENDING CMS APPROVAL

FINTEPLA

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Dravet Syndrome or Lennox Gaustaut Syndrome 2. Previous use of two of topiramate, valproic acid, or clobazam

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FIRAZYR

MEDICATION(S)

ICATIBANT ACETATE

PENDING CMS APPROVAL

FOTIVDA

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC) 2. Previous failure of two systemic therapies

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FRUZAQLA

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of metastatic colorectal cancer (mCRC) 2. Member has previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy 3. Member has failed, contraindication, or intolerance to Lonsurf with or without bevacizumab

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GATTEX

MEDICATION(S)

GATTEX

PENDING CMS APPROVAL

GAVRETO

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of non-smallcell lung cancer (NSCLC) A. Metastatic NSCLC identified as rearranged during transfection (RET) fusion-positive 2. Dx of thyroid cancer A. Advanced or metastatic RET fusion-positive thyroid cancer refractory radioactive iodine (if appropriate) requiring systemic therapy

AGE RESTRICTION
12 and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GILOTRIF

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of metastatic non-small cell lung cancer (NSCLC)
   a. The tumor has an epidermal growth factor receptor (EGFR) mutation
2. Dx of metastatic squamous non-small cell lung cancer (NSCLC)
   a. Progression after platinum-based chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLEOSTINE

MEDICATION(S)
LOMUSTINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of primary and metastatic brain tumors following appropriate surgical and/or radiotherapeutic procedures 2. Dx of Hodgkin's lymphoma A. Disease has progressed following initial chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GOMEKLI

MEDICATION(S)
GOMEKLI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Previous treatment with prior MEK inhibitor

REQUIRED MEDICAL INFORMATION
1. Diagnosis of documented NF1 mutation or diagnosis of NF1 using NIH Consensus Conference criteria inclusive of presence of a plexiform neurofibromas (PN) not amenable to complete resection
2. Intolerance, contraindication or documentation explaining why treatment with Koselugo is inappropriate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GROWTH HORMONE

MEDICATION(S)

GENOTROPIN, GENOTROPIN MINIQUICK, OMNITROPE

PENDING CMS APPROVAL

HAEGARDA

MEDICATION(S)
HAEGARDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For HAE type I and II and acquired angioedema:
   A. Dx has been confirmed by C1-INH and/or C1-INH function levels
2. For HAE with normal C1-INH:
   A. Dx has been confirmed based on C4, C1-INH antigen, C1-INH function, genetic testing, and/or family history.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HARVONI

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Chart notes showing genotype

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Maximum 24 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HEMADY

MEDICATION(S)
HEMADY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of Multiple Myeloma (MM) 2. Previous use of generic dexamethasone tablets

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HEPATITIS C

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For Hep B dx:
   a. Pre-treatment HBV DNA levels are greater than 20,000 IU/ml OR patient is in the indeterminate phase
   b. Must be used as monotherapy
2. Hep C dx

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
48 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HERNEXEOS

MEDICATION(S)

HERNEXEOS

PENDING CMS APPROVAL

HUMIRA

MEDICATION(S)

AMJEVITA 20 MG/0.2ML SOLN PRSYR, AMJEVITA 40 MG/0.4ML SOLN A-INJ, AMJEVITA 40 MG/0.4ML SOLN PRSYR, AMJEVITA 80 MG/0.8ML SOLN A-INJ, AMJEVITA-PED 15KG TO <30KG 20 MG/0.2ML SOLN PRSYR, HADLIMA, HADLIMA PUSHTOUCH

PENDING CMS APPROVAL

HYRNUO

MEDICATION(S)
HYRNUO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC)
2. Confirmed HER2 (ERBB2) TKD activating mutation, as detected by an FDA-approved test

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IBERDOMIDE

MEDICATION(S)

ZENBEXUS

PENDING CMS APPROVAL

IBRANCE

MEDICATION(S)
IBRANCE 100 MG TAB, IBRANCE 125 MG CAP, IBRANCE 125 MG TAB, IBRANCE 75 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer
   a. Ibrance used as initial therapy:
      i. Used in combination with an aromatase inhibitor,
   b. Ibrance used after endocrine-based therapy:
      i. Used in combination with fulvestrant
2. Dx of endocrine-resistant, PIK3CA-mutated, HR-positive, HER2-negative, locally advanced or metastatic breast cancer
   a. Ibrance used following recurrence on or after completing adjuvant endocrine therapy
      i. used in combination with inavolisib and fulvestrant
3. Diagnosis of HR-positive, HER2-positive locally advanced or metastatic breast cancer
   a. Used after induction treatment for maintenace treatment
      i. Use in combination with trastuzumab, with or without pertuzumab, and endocrine therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

IBTROZI

MEDICATION(S)
IBTROZI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Patients with interstitial fibrosis or interstitial lung disease
2. Ongoing cardiac dysrhythmias of NCI CTCAE (v5.0) Grade greater than or equal to 2, uncontrolled atrial fibrillation of any grade, or QTc interval greater than 470 microsec
3. Patients taking strong CYP3A inhibitors (ie. atazanavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, troleandomycin, voriconazole)

4. Patients taking strong CYP3A4 inducers (i.e. carbamazepine, phenobarbital, phenytoin, rifabutin, rifampin, and St John's Wort)
5. Patient taking strong CYP3A4 substrates with narrow therapeutic indices (i.e. dihydroergotamine, ergotamine, pimozide, astemizole, cisapride, and terfenadine)
6. Patient is taking any medication that is known to induce QTc prolongation

REQUIRED MEDICAL INFORMATION
1. Patient has locally advanced or metastatic NSCLC
2. Patient has documented ROS1+ fusion
3. Reason of medical necessity or contraindication/intolerance to the use of entrectinib (Rozlytrek)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ICLUSIG

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Chronic Phase CML dx
   a. Resistance or intolerance to dasatinib
2. Accelerated or Blast phase CML OR Ph+ ALL
   a. No other TKI is indicated
3. T315I-positive CML or T315I-positive ALL
4. Newly diagnosed Ph+ ALL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

IDHIFA

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Cancer has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a FDA-approved test,
2.Pt has relapsed or is refractory to one or more prior anticancer regimens

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IMBRUVICA

MEDICATION(S)
IMBRUVICA 140 MG CAP, IMBRUVICA 140 MG TAB, IMBRUVICA 280 MG TAB, IMBRUVICA 420 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of CLL/SLL 2. Dx of CLL/SLL w/ 17p deletion 3. Dx of Waldenstrom's Macroglobinemia 4. Dx of cGVHD: a. Member has failed at least one prior systemic therapy b. Prescribing physician is a specialist in transplant

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IMKELDI

MEDICATION(S)
IMKELDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt is unable to swallow tablets

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INCRELEX

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Height standard deviation score of less than -3 based on age and gender, 2. Basal IGF-1 standard deviation score of less than -3 based on age and gender, 3. Normal or elevated growth hormone levels, 4. Pt must have open epiphyses, 5. Gh stimulation test of greater than 10 mcg/L.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INLURIYO

MEDICATION(S)
INLURIYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of advanced or metastatic ER+, HER2- breast cancer
2. Confirmation of ESR1-mutated breast cancer
3. The patient has experienced disease progression following at least one line of endocrine therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INLYTA

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of renal cell carcinoma 2. For first line treatment in combination with pembrolizumab (Keytruda) or avelumab (Bavencio) 3. Monotherapy as a second line treatment after previous use of one prior systemic therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INQOVI

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of myelodysplastic syndrome
2. Diagnosis of newly diagnosed acute myeloid leukemia in adults who have comorbidities that preclude use of intensive induction chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INREBIC

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A. Diagnosis of intermediate or high-risk primary or secondary myelofibrosis B. Platelet count greater than or equal to 50x10^9/L

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IRESSA

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has ONE of the following: a. EGFR exon 19 deletion, b. EGFR exon 21 (L858R) substitution, 2. Gefitinib is used as first-line therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ITOVEBI

MEDICATION(S)
ITOVEBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Disease progression on or following other PI3k inhibitors

REQUIRED MEDICAL INFORMATION
1. Pt must have advanced or metastatic HR-positive, HER2-negative breast cancer with documented PIK3CA mutation 2. Pt must have disease progression following at least one line of endocrine therapy in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy 3. Itovebi will be given in combination with Ibrance (palbociclib) and fulvestrant as first-line therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVIG

MEDICATION(S)
BIVIGAM, GAMMAGARD 1 GM/10ML SOLUTION, GAMMAGARD 20 GM/200ML SOLUTION, GAMMAGARD 2.5 GM/25ML SOLUTION, GAMMAGARD 30 GM/300ML SOLUTION, GAMMAGARD S/D LESS IGA, GAMMAKED 1 GM/10ML SOLUTION, GAMMAPLEX, GAMUNEX-C 1 GM/10ML SOLUTION, OCTAGAM 10 GM/100ML SOLUTION, OCTAGAM 10 GM/200ML SOLUTION, OCTAGAM 1 GM/20ML SOLUTION, OCTAGAM 25 GM/500ML SOLUTION, OCTAGAM 2.5 GM/50ML SOLUTION, OCTAGAM 2 GM/20ML SOLUTION, OCTAGAM 30 GM/300ML SOLUTION, OCTAGAM 5 GM/100ML SOLUTION, PRIVIGEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)For all non-preferred IVIG products (ie Bivigam, Gammaked, Octagam, etc) a)Must try TWO of the following: Gammagard, Gamunex, Hizentra, and Privigen OR b)Documented medical reason why preferred agents cannot be used

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvD Determination

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

IWILFIN

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of high risk neuroblastoma (HRNB) in patients who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy 2. Maximum duration of 2 years of therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JADENU

MEDICATION(S)

DEFERASIROX 180 MG PACKET, DEFERASIROX 250 MG TAB SOL, DEFERASIROX 360 MG PACKET, DEFERASIROX 500 MG TAB SOL, DEFERASIROX 90 MG PACKET, DEFERASIROX GRANULES

PENDING CMS APPROVAL

JAKAFI

MEDICATION(S)

JAKAFI, JAKAFI XR

PENDING CMS APPROVAL

JAYPIRCA

MEDICATION(S)

JAYPIRCA

PENDING CMS APPROVAL

JYNARQUE

MEDICATION(S)
TOLVAPTAN, TOLVAPTAN (HYPONATREMIA)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
eGFR less than 25ml/min

REQUIRED MEDICAL INFORMATION
1. Diagnosis of autosomal dominant polycystic kidney disease
   a. Diagnosis has been confirmed by radiology
2. Diagnosis of hypervolemic or euvolemic hyponatremia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist, nephrologist, cardiologist and hepatologist.

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KALYDECO

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial: A. Pt genotyped by an FDA-cleared CF mutation test B. Pt have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data 2. Reauth: A. Pt has been reassessed since starting therapy

AGE RESTRICTION
Tablet: 6 years old or older, Granules: 1 months old to 5 years old

PRESCRIBER RESTRICTION
Specialist in Cystic Fibrosis or Pulmonologist

COVERAGE DURATION
Initial: 6 months Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KERENDIA

MEDICATION(S)

KERENDIA

PENDING CMS APPROVAL

KEVEYIS

MEDICATION(S)
DICHLORPHENAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Hypersensitivity to dichlorphenamide or other sulfonamides 2. Use in combination with high-dose aspirin 3. Severe pulmonary disease 4. Hepatic insufficiency (e.g Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION
1. Dx of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants. 2. Previous use or contraindication to acetazolamide 3. Reauthorization: a. improvement in baseline symptoms (e.g. number of attacks per week or month, severity of attacks, duration of attacks, short-form 36 assessment, etc.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauthorization: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KINERET

MEDICATION(S)
KINERET

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Dx of Recurrent Pericarditis

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Rheumatoid Arthritis (RA)
   A. Member has tried and failed TWO of the following: adalimumab (ie Amjevita or Hadlima), infliximab (ie renflexis), or tofacitinib
2, Dx of Cryopyrin-Associated Periodic Syndromes (CAPS)
3. Dx of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
4. Dx of Recurrent Pericarditis
   A. Member has tried and failed colchicine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED

YES

KISQALI

MEDICATION(S)
KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE), KISQALI FEMARA (200 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer, must meet ONE of the following: a. Pt will receive an aromatase inhibitor in combination with Kisqali as initial endocrine based therapy for advanced or metastatic disease, b. Pt will receive fluvestrant in combination with Kisqali 2. Dx of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II or stage III early breast cancer at high risk of recurrence a. Pt will receive an aromatase inhibitor in combination with Kisqali

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

KOMZIFTI

MEDICATION(S)
KOMZIFTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Relapsed or refractory acute myeloid leukemia (AML) adult patients with nucleophosmin 1 (NPM1) mutation who have no satisfactory alternative treatment options

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KORLYM

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pt using long-term corticosteroid

REQUIRED MEDICAL INFORMATION
1. Pt has previously failed surgery or chemotherapy to correct Cushing's disease OR is ineligible for surgery,

2. If pt is female:

a. Pt has negative pregnancy test within past 14 days,

b. Pt is currently using non-hormonal form of birth control

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Initial: 6 months, Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

KOSELUGO

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Patient has symptomatic, inoperable plexiform neurofibromas (PN)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KRAZATI

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Previous KRAS G12C-targeted therapy (other than current)

REQUIRED MEDICAL INFORMATION
1. Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC): a. At least one prior systemic therapy 2. Diagnosis of KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC): a. Received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, b. Used in combination with cetuximab

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauthorization: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

KYNMOBI

MEDICATION(S)
APOMORPHINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Parkinson's disease A. Experiencing off episodes 2. Currently taking an oral formulation of carbidopa/levodopa or there is documentation of an inability to take an oral formulation of carbidopa/levodopa 3. Previous use of an immediate release or oral disintegrating carbidopa/levodopa as a rescue for off episodes 4. Previous use of at least one of: a. COMT inhibitor (tolcapone, entacapone), b. Dopamine agonist (ropinirole, pramipexole), c. MAO-B inhibitor (selegiline, rasagiline, safinamide) 5. Prescribed in combination with antiemetic therapy (Not a 5HT3)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

LAMPIT

MEDICATION(S)
LAMPIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Chagas disease (T. cruzi)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAZCLUZE

MEDICATION(S)
LAZCLUZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Prior systemic treatment for locally advanced Stage III or metastatic Stage IV disease 2. Symptomatic or previously treated unstable brain metastases

REQUIRED MEDICAL INFORMATION
1. Initial A. Patient must have confirmed NSCLC that is metastatic or unresectable with EGFR exon 19 deletions or 21 L858R substitution mutations. B. Patient must receive anticoagulant prophylaxis to prevent VTE events for the first 4 months of treatment. C. Reason of medical necessity or contraindication/intolerance to the use of osimertinib (Tagrisso)

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LENVIMA

MEDICATION(S)
LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Renal cell carcinoma dx: a. Will be used in combination with everolimus OR pembrolizumab 2. Thyroid cancer dx: a. Tumor is refractory to treatment with radioactive iodine, b. Used as monotherapy 3. Unresectable hepatocellular carcinoma dx: 4. Endometrial carcinoma dx: a. Will be used in combination with pembrolizumab (Keytruda) b. Does not have microsatellite instability-high or mismatch repair deficiency c. Pt has previously been treated with systemic therapy d. Pt is not a candidate for surgery or radiation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

LEUKERAN

MEDICATION(S)
LEUKERAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of:
   a. chronic lymphatic (lymphocytic) leukemia
   b. malignant lymphomas including lymphosarcoma,
   c. giant follicular lymphoma
   d. Hodgkins disease

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEUKINE

MEDICATION(S)
LEUKINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of: a. To shorten time to neutrophil recovery and to reduce the incidence of severe and life-threatening infections and infections resulting in death following induction chemotherapy in adult patients 55 years and older with acute myeloid leukemia (AML). i. Pt has trial on BOTH of the following: a. Fulphila, b. Udenyca b, For the mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis and autologous transplantation. c. For the acceleration of myeloid reconstitution following autologous bone marrow or peripheral blood progenitor cell transplantation. d. For the acceleration of myeloid reconstitution following allogeneic bone marrow transplantation. e. For treatment of delayed neutrophil recovery or graft failure after autologous or allogeneic bone marrow transplantation. f. To increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvD Determination

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LIFYORLI

MEDICATION(S)
LIFYORLI (125 MG DOSE), LIFYORLI (150 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Concurrent systemic glucocorticoid therapy for a lifesaving indication

REQUIRED MEDICAL INFORMATION
1. A diagnosis of platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal carcinoma
2. Platinum-resistant disease is defined by relapse within 6 months of prior platinum-based therapy
3. Used in combination with paclitaxel protein bound (nab-paclitaxel)
4. Has received one to three prior systemic treatment regimens, at least one of which included bevacizumab

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
YES

LIVTENCITY

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Combination use with valganciclovir or ganciclovir

REQUIRED MEDICAL INFORMATION
1. Pt weighs at least 35 kg or more 2. History of hematopoietic stem cell transplant (HSCT) or solid organ transplant (SOT) 3. Diagnosis of post-transplant CMV infection/disease 4. CMV disease refractory to or intolerant of first line antiviral treatment (e.g., ganciclovir, valganciclovir, foscarnet, or cidofovir)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
8 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LONSURF

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A. Metastatic colorectal cancer 1. Pt has previous therapy on the following: a. A fluoropyrimidine, b. Oxaliplatin, c. Irinotecan, d. Bevacizumab, 2. If cancer is KRAS wild type, pt has received previous therapy with anti-EGFR therapy B. Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LORBRENA

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Dx of metastatic non-small cell lung cancer (NSCLC) a) Tumors are anaplastic lymphoma kinase (ALK)-positive 2) Patient has failed/intolerance/contraindication to Alecensa

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUCEMYRA

MEDICATION(S)
LOFEXIDINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Mitigation of opioid withdrawal symptoms 2. Provider submitted documentation that the patient has been counseled on the risks of taking lofexidine with alcohol, benzodiazepines, and barbituates 3. Patient has failed clonidine as part of this opioid discontinuation attempt

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
14 Days

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUMAKRAS

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Previous KRAS G12C-targeted therapy (other than current)

REQUIRED MEDICAL INFORMATION
1. Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC): a. At least one prior systemic therapy, 2. Diagnosis of KRAS G12C-mutated Metastatic Colorectal Cancer (mCRC): a. Received prior treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, b. Used in combination with panitumumab

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauthorization: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUPKYNIS

MEDICATION(S)

LUPKYNIS

PENDING CMS APPROVAL

LYBALVI

MEDICATION(S)
LYBALVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Bipolar 1 Disorder or Schizophrenia: Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LYNPARZA

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Ovarian cancer, advanced (BRCA-mutated):
a. First-line maintenance therapy for gBRCAm or sBRCAm advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adult patients with complete or partial response to first-line platinum-based chemotherapy, OR
b. First-line maintenance treatment (in combination with bevacizumab) of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adults who are in complete or partial response to first-line, platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD)-positive status,
2. Recurrent ovarian cancer dx:
a. Maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in adults who are in complete or partial response to platinum-based chemotherapy.
3. Breast Cancer (BRCA-mutated, HER2-negative) dx:
a. For Metastatic Breast Cancer: Pt has previous trial of chemotherapy in neoadjuvant, adjuvant, or metastatic setting
i. If HR positive: pt has t/f endocrine therapy or endocrine therapy is inappropriate for pt
b. For High Risk Early Breast Cancer: Pt has previous trial of chemotherapy in neoadjuvant, adjuvant, or metastatic setting
4. Pancreatic cancer (BRCA-mutated):
a. disease has not progressed on at least 16 weeks of a first-line, platinum-based chemotherapy regimen
5. Prostate cancer (mCRPC):
a. Homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate

cancer in adults who have progressed following prior enzalutamide or abiraterone treatment

b. BRCA-mutated (BRCAm) metastatic castration resistant prostate cancer (mCRPC) in combination with abiraterone and prednisone or prednisolone

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LYTGOBI

MEDICATION(S)
LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of metastatic cholangiocarcinoma 2. Previous treatment for metastatic cholangiocarcinoma with at least 1 line of systemic therapy 3. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MACITENTAN

MEDICATION(S)
MACITENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of PAH: a. Previous trial of ambrisentan or bosentan

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MAVYRET

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of genotype

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
16 Weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEKINIST

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Will be used as monotherapy for:

a. Dx of unresectable or metastatic melanoma with BRAF V600E or V600K mutations in BRAF-inhibitor treatment-naïve patients

2. Will be used in combination with dabrafenib for:

a. Dx of unresectable or metastatic melanoma with BRAF V600E or V600K mutations

b. The adjuvant treatment of patients with dx of melanoma with BRAF V600E or V600K mutations and involvement of lymph node(s), following complete resection.

c. Dx of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation

d. Dx of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options.

e. Dx of unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options.

f. Dx of low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy.

3. For oral solution: member has inability to swallow tablets

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

METYROSINE

MEDICATION(S)
METYROSINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has failed phenoxybenzamine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MIGRANAL

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has trial or contraindication to at least TWO of the following: a. Sumatriptan, b. Rizatriptan, c. Zolmitriptan, d. Naratriptan

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MODEYSO

MEDICATION(S)
MODEYSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of diffuse midline glioma
2. Confirmation of H3 K27M mutation via tumor tissue-based testing performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory using immunohistochemistry (IHC) or DNA sequencing
3. Patient has had disease progression after a trial and failure of previous therapy
4. Chart notes required with current body weight documented

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

MULPLETA

MEDICATION(S)
MULPLETA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Platelet count less than 50,000 2. Pt is scheduled for a procedure where there is a bleeding risk 3. Mulpleta will be used for 7 days starting 8 to 14 days prior to the procedure and discontinued 2 to 8 days prior to the procedure

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MYALEPT

MEDICATION(S)
MYALEPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of leptin deficiency in patients with congenital or acquired generalized lipodystrophy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months, Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MYFEMBREE

MEDICATION(S)
MYFEMBREE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Maximum lifetime duration 24 months

REQUIRED MEDICAL INFORMATION
1. Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) 2. Moderate to Severe Pain Associated with Endometriosis 3. Premenopausal 4. Previous use of a combination oral contraceptive 5. Previous use of a progestin-only contraceptive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NARCOLEPSY

MEDICATION(S)
WAKIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with severe hepatic impairment

REQUIRED MEDICAL INFORMATION
1. For narcolepsy with cataplexy
   a. Patient has been diagnosed by a board certified sleep, pulmonology, or neurology specialist
   b. Patient exhibits symptoms of cataplexy
2. For excessive daytime sleepiness (EDS)
   a. Patient has been diagnosed by a board certified sleep, pulmonology, or neurology specialist
   b. Pt has tried and failed, has intolerance to, or has contraindication for TWO of the following (documentation of failure, intolerance or contraindication must be provided):
      i. Sunosi, armodafinil, modafinil

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Board certified in sleep, pulmonology, or neurology

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

NERLYNX

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Breast cancer dx: a. Tx of early stage HER2-positive breast cancer following adjuvant trastuzumab-based therapy OR b. Tx of HER2-positive breast cancer, in combination with capecitabine, in patients who have received 2 or more prior regimens for metastatic disease

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NEULASTA

MEDICATION(S)
ARMLUPEG, FYLNETRA, NEULASTA 6 MG/0.6ML SOLN PRSYR, NYVEPRIA, STIMUFEND, ZIEXTENZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Neutropenia
a. If requesting Fylnetra, Neulasta, Nyvepria, Stimufend, or Ziextenzo, pt has trial on BOTH of the following: a. Fulphila, b. Udenyca 2. For Fylnetra, Neulasta, Stimufend, Ziextenzo: Dx of acute hematopoietic radiation injury syndrome a. Pt has trial of Udenyca

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvsD Determination

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NEXAVAR

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Unresectable hepatocellular carcinoma

2. Dx of Advanced renal cell carcinoma

3. Dx of Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC) refractory to radioactive iodine treatment

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

NEXLETOL

MEDICATION(S)
NEXLETOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. The patient has one of the following:
  a. A diagnosis of familial hypercholesterolemia
  b. Established atherosclerotic cardiovascular disease (ASCVD)
  c. The patient has primary hyperlipidemia OR is considered high risk for cardiovascular disease without established ASCVD,
    i. AND has documented intolerance to statin therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

NEXLIZET

MEDICATION(S)
NEXLIZET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. The patient has one of the following:
a. A diagnosis of familial hypercholesterolemia
b. Established atherosclerotic cardiovascular disease (ASCVD)
c. The patient has primary hyperlipidemia OR is considered high risk for cardiovascular disease without established ASCVD,
i. AND has documented intolerance to statin therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

NICOTROL

MEDICATION(S)
NICOTROL NS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has tried varenicline or bupropion OR has a contraindication to the use of varenicline or bupropion (established seizure disorder, concurrent anorexia or bulimia, concurrent use of MAOIs, etc)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NINLARO

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Autologous Stem Cell Transplant

EXCLUSION CRITERIA
1. Pt is refractory to lenalidomide or proteasome inhibitor therapy

REQUIRED MEDICAL INFORMATION
1. Multiple Myeloma

a. Combination with lenalidomide (Revlimid) and dexamethasone

b. Pt has previous trial on at least ONE other therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NITROFURAN

MEDICATION(S)
NITROFURANTOIN 25 MG/5ML SUSPENSION, NITROFURANTOIN 50 MG/10ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Unable to swallow nitrofurantoin capsules

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NORTHERA

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has previous trial on BOTH of the following: a. Midorine, b. Fludrocortisone

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NOXAFIL

MEDICATION(S)
NOXAFIL 300 MG PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For the prophylaxis of invasive Aspergillus and Candida infections in patients who are at high risk of developing these infections due to being severely immunocompromised
2. For the treatment of invasive aspergillus
3. Body weight of 40 kg or less

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 Months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NUBEQA

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC)
   a. Patient has PSA doubling time of less than or equal to 10 months
   b. Reason of medical necessity or contraindication/intolerance to the use of enzalutamide (Xtandi)
2. Diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC)
   a. Reason of medical necessity or contraindication/intolerance to the use of abiraterone 250mg AND enzalutamide (Xtandi)
   b. Given either as monotherapy or in combination with docetaxel

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

NUPLAZID

MEDICATION(S)

NUPLAZID

PENDING CMS APPROVAL

NURTEC

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For Acute Treatment of Migraines:
a. Patient has tried 2 generic triptan medications OR has a contraindication to the use of triptans (e.g. established cardiovascular disease or cerebrovascular disease)
2. For preventive treatment of episodic migraine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OCTREOTIDE

MEDICATION(S)
OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For acromegaly: A. Has patient failed at least ONE of the following: i. Surgical resection, ii. Pituitary irradiation, 2. Dx of metastatic carcinoid tumors: c. Dx of vasoactive intestinal peptide secreting tumors (VIPoma)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
BvsD determination

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ODOMZO

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has recurring lesions after radiation therapy OR radiation therapy is contraindicated or inappropriate, 2. Pt has recurring lesions after surgical excision OR surgery is contraindicated or inappropriate

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OFEV

MEDICATION(S)

NINTEDANIB ESYLATE, OFEV

PENDING CMS APPROVAL

OGSIVEO

MEDICATION(S)
OGSIVEO 100 MG TAB, OGSIVEO 150 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of desmoid tumor/aggressive fibromatosis with documentation of tumor progression 2. Contraindication, intolerance, or failure of sorafenib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OJEMDA

MEDICATION(S)
OJEMDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Patient with tumors harboring additional activating molecular alteration(s) (e.g. IDH1/2 mutations, FGFR mutations, etc) or patients with known or suspected diagnosis of neurofibromatosis type 1 (NF1)

REQUIRED MEDICAL INFORMATION
1. Dx of relapsed or refractory pediatric low-grade glioma (LGG) harboring BRAF fusion or rearrangement, or BRAF V600 mutation
2. For BRAF V600-positve, a reason of medical necessity or contraindication/intolerance to the use of dabrafenib (Tafinlar) and trametinib (Mekinist)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OJJAARA

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF (postpolycythemia vera (PV) and post-essential thrombocythemia (ET)) 2. Hemoglobin less than 10g/dL 3. Member has tried and failed or has intolerance to Jakafi

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OMNIPOD

MEDICATION(S)
OMNIPOD 5 DEXG7G6 PODS GEN 5, OMNIPOD 5 G7 PODS (GEN 5), OMNIPOD 5 LIBRE PODS, OMNIPOD DASH PODS (GEN 4)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus, Diabetes adjunctive to kidney transplant, or Diabetes in pregnancy
2. For Type 2 diabetes, patient has failed to demonstrate satisfactory diabetic control despite documentation of strict compliance to an aggressive treatment standard regimen (i.e., frequent glucose monitoring-minimum of 4 times a day), multiple daily injections (3 or more), and formal diabetic education (Please note, a provider attestation is required)
3. Patient has attended two diabetic medical provider visits within the last 12 months with at least one visit with the prescribing provider and has demonstrated compliance with the therapeutic regimen (Please note, a provider attestation is required)
Replacements will only be allowed when ALL the following criteria are met:
a. If applicable, the patient's current device (e.g. Tandem, Medtronic, iLet insulin pump) is out of warranty and the device is malfunctioning
i. If yes, damage was not due to patient neglect or abuse
b. Patient must have attended two diabetic medical provider visits within the last 12 months with at least one visit with the prescribing provider and has demonstrated compliance with the therapeutic regimen.
4. Please note, provider attestation is required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OMVOH

MEDICATION(S)

OMVOH 100 MG/ML SOLN A-INJ, OMVOH 100 MG/ML SOLN PRSYR, OMVOH 200 MG/2ML SOLN A-INJ, OMVOH 200 MG/2ML SOLN PRSYR, OMVOH (300 MG DOSE)

PENDING CMS APPROVAL

ONFI

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1.Pt has previous trial on at least TWO AED medications
2.Pt is intolerant or is unable to use clobazam suspension

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ONUREG

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of one of: A. acute myeloid leukemia (AML) who achieved first complete remission (CR) B. AML in complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and the member is not able to complete intensive curative therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OPIPZA

MEDICATION(S)
OPIPZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Major Depressive Disorder (MDD) or Schizophrenia: Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ORFADIN

MEDICATION(S)

NITISINONE, ORFADIN 4 MG/ML SUSPENSION

PENDING CMS APPROVAL

ORGOVYX

MEDICATION(S)

ORGOVYX

PENDING CMS APPROVAL

ORIAHNN

MEDICATION(S)
ORIAHNN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Maximum lifetime duration 24 months

REQUIRED MEDICAL INFORMATION
1. Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) 2. Premenopausal 3. Previous use of a combination oral contraceptive 4. Previous use of a progestin-only contraceptive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ORILISSA

MEDICATION(S)
ORILISSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) previous use of combination oral contraceptive 2) previous use of progestin-only contraceptive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year Orilissa 150 mg, maximum lifetime duration 24 months 6 months Orilissa 200 mg

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ORSERDU

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Postmenopausal female or male with a diagnosis of advanced or metastatic ER+, HER2- breast cancer 2. Confirmation of ESR1-mutated breast cancer 3. The member has experienced disease progression following at least one line of endocrine therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OSTEOPOROSIS

MEDICATION(S)

TERIPARATIDE

PENDING CMS APPROVAL

OTEZLA

MEDICATION(S)

OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA XR

PENDING CMS APPROVAL

PALYNZIQ

MEDICATION(S)
PALYNZIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. If PKU dx:

a. Pt has trial on sapropterin therapy

2. All dx:

a. Pt has a blood phenylalanine (Phe) concentration of greater than 600 micromol/L

3. For dose increase to 60mg/day

a. Patient has had two consecutive blood phenylalanine (Phe) concentrations greater than 360 micromol/L on existing management as recommended by the American College of Medical Genetics and Genomics (ACMG) guidelines

4. Palynziq will be used in combination with a dietary phenylalanine restriction (documentation of compliance with dietary phenylalanine restriction provided with request)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PANRETIN

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1.Systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement)

REQUIRED MEDICAL INFORMATION
1. Dx of cutaneous lesions in patients with AIDS-related Karposi's Sarcoma

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PART D PA

MEDICATION(S)

BEQALZI, BEQALZI STARTER PACK, ETCAMAH, MIMRYLO, ZEGFROVY

PENDING CMS APPROVAL

PART D VS PART B

MEDICATION(S)

ABILIFY ASIMTUFII, ABILIFY MAINTENA, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, APREPITANT, ARANESP (ALBUMIN FREE), ARFORMOTEROL TARTRATE, ARISTADA, ARISTADA INITIO, AZATHIOPRINE, BILDYOS, BILPREVDA, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, ELIGARD, ENGERIX-B, ENVARSUS XR, EPOGEN, ERZOFRI, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FIRMAGON, FIRMAGON (240 MG DOSE), FLUPHENAZINE DECANOATE, FLUPHENAZINE HCL 2.5 MG/ML SOLUTION, FORMOTEROL FUMARATE, FULPHILA, GENGRAF 100 MG CAP, GENGRAF 25 MG CAP, GRANISETRON HCL 1 MG TAB, GRANIX 300 MCG/0.5ML SOLN PRSYR, GRANIX 300 MCG/ML SOLUTION, GRANIX 480 MCG/0.8ML SOLN PRSYR, HALOPERIDOL DECANOATE, HALOPERIDOL LACTATE 5 MG/ML SOLUTION, HEPLISAV-B, INVEGA HAFYERA, INVEGA SUSTENNA, INVEGA TRINZA, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, JUBBONTI, LEVALBUTEROL HCL, LILETTA (52 MG), LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH), LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT, LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT, LUTRATE DEPOT, METHOTREXATE SODIUM 250 MG/10ML SOLUTION, METHOTREXATE SODIUM 50 MG/2ML SOLUTION, METHOTREXATE SODIUM (PF), MICAFUNGIN SODIUM, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NIVESTYM, OLANZAPINE 10 MG RECON SOLN, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PULMOZYME, RECOMBIVAX HB, RETACRIT, RISPERIDONE MICROSPHERES ER, SIROLIMUS, SODIUM CHLORIDE 0.9 % SOLUTION, STREPTOMYCIN SULFATE, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TACROLIMUS ER, TRELSTAR MIXJECT, TWINRIX, UDENYCA, UZEDY, VARUBI (180 MG DOSE), WYOST, ZIPRASIDONE MESYLATE

DETAILS

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

PCSK

MEDICATION(S)

REPATHA, REPATHA SURECLICK

PENDING CMS APPROVAL

PEMAZYRE

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma A. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test 2. Relapsed or refractory myeloid/lymphoid neoplasms i. Fibroblast growth factor receptor 1 (FGFR1) rearrangement as detected by an FDA-approved test

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHENOXYBENZAMINE

MEDICATION(S)
PHENOXYBENZAMINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Used for short-term treatment of hypertension prior to surgical removal of a pheochromocytoma

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 Months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHOSPHATE BINDERS

MEDICATION(S)

VELPHORO

PENDING CMS APPROVAL

PIQRAY

MEDICATION(S)
PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer a. PIK3CA-mutation positive b. Receiving or previous use of an endocrine-based regimen

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

POMALYST

MEDICATION(S)
POMALIDOMIDE, POMALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Multiple myeloma dx:
   a. Pt has tried BOTH of the following:
      i. lenalidomide
      ii. bortezomib,
   b. Pt has demonstrated disease progression within 60 days of completion of prior therapy
   c. Will be used in combination with dexamethasone
2. Kaposi sarcoma dx:
   a. Experienced failure of highly active antiretroviral therapy (HAART) in patient with AIDS
   b. HIV-negative

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

PRETOMANID

MEDICATION(S)
PRETOMANID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of tuberculosis 2. Used as part of an appropriate treatment regimen (e.g. bedaquiline and linezolid)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PREVYMIS

MEDICATION(S)
PREVYMIS 120 MG PACKET, PREVYMIS 20 MG PACKET, PREVYMIS 240 MG TAB, PREVYMIS 480 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pt has Child-Pugh class C hepatic impairment

REQUIRED MEDICAL INFORMATION
1. For: CMV prophylaxis in HSCT recipients a. Pt is post allogenic hematopoietic stem cell transplant within the last 28 days OR patient had an intolerance to valganciclovir or ganciclovir b. Pt is a CMV-seropositive recipient [R+] 2. For: CMV prophylaxis in kidney transplant recipients a. Pt is post kidney transplant within last 7 days OR patient had an intolerance to valganciclovir or ganciclovir b. Pt is high risk (Donor CMV seropositive/Recipient CMV seronegative) 3. Medication will be discontinued on or before 200 days post-transplantation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
200 days

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

PROLASTIN

MEDICATION(S)
PROLASTIN-C

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has severe congenital alpha-1 proteinase inhibitor (A1PI) deficiency, defined as either nephelometry (levels less than 50mg/dL or less than 9micromol/L) or by radial immunodiffusion (levels less than 80mg/dL or less than 15micromol/L). Laboratory results must be submitted 2. Patient has either PiZZ or PiSZ genotype

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvD determination required

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PROMACTA

MEDICATION(S)
ELTROMBOPAG OLAMINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For ITP dx:
   a. Persistent or chronic ITP
   b. Insufficient response to corticosteroids, immunoglubulins, OR splenectomy,
   c. Degree of thrombocytopenia and clinical condition increase the risk for bleeding
2. For Hep C with Thrombocytopenia dx:
   a. Used when the degree of thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy
3. For aplastic anemia dx:
   a. Pt has an insufficient response to immunosuppressive therapy
   b. In combination with immunosuppressive therapy for severe aplastic anemia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 Months

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

PURIXAN

MEDICATION(S)
MERCAPTOPURINE 2000 MG/100ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Used in conjunction with a combination chemotherapy treatment regimen for ALL, 2. Pt is unable to swallow mercaptopurine tablets

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PYRUKYND

MEDICATION(S)
PYRUKYND, PYRUKYND TAPER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Homozygous R479H mutation or 2 non-missense mutations, without the presence of another missense mutation, in the PKLR gene

REQUIRED MEDICAL INFORMATION
1. Initial:
a. Confirmed diagnosis of pyruvate kinase (PK) deficiency, with presence of at least 2 mutant alleles in PKLR gene, of which at least 1 is a missense mutation
b. Patient has hemolytic anemia due to PK deficiency
c. Patient has received RBC transfusions within the past year OR has a hemoglobin of less than or equal to 10 g/dL

2. Reauth:
a. Increase in hemoglobin of greater than or equal to 1.5 g/dL compared with pre-treatment baseline OR a reduction in RBC transfusion burden from pre-treatment baseline

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

QINLOCK

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of advanced GIST 2. Prior treatment with 3 or more kinase inhibitors, including imatinib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RCC

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB, EVEROLIMUS 5 MG TAB SOL, EVEROLIMUS 7.5 MG TAB, TORPENZ, YULITHIRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
For renal angiomyolipoma, requires immediate surgery

REQUIRED MEDICAL INFORMATION
1. For RCC dx:
    a. Previous failure on either sunitinib or Nexavar,

2. For SEGA or TS dx:
    a. Patient must require therapeutic intervention and not be a candidate for surgical resection

3. Diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) or with well-differentiated, nonfunctional neuroendocrine tumors (NET) of gastrointestinal (GI), or lung origin which are unresectable, locally advanced or metastatic

4. Diagnosed with renal angiomyolipoma with tuberous sclerosis complex with at least one angiomyolipoma greater than or equal to 3cm where there is not an immediate need for surgery

5. Hormone receptor positive HER2-negative breast cancer
    a. Previous use of one of letrozole or anastrozole
    b. Use in combination with one of exemastane, tamoxifen, or fulvestrant

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

RETEVMO

MEDICATION(S)
RETEVMO 120 MG TAB, RETEVMO 160 MG TAB, RETEVMO 40 MG TAB, RETEVMO 80 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of: a. Locally advanced or metastatic RET fusion-positive non-small cell lung cancer (NSCLC) b. Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in patients who require systemic therapy c. Advanced or metastatic RET fusion-positive thyroid cancer in patients who require systemic therapy and refractory to radioactive iodine, if appropriate d. Locally advanced or metastatic solid tumors with a RET gene fusion, that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options 2. Identification of a RET gene alteration using next generation sequencing (NGS), polymerase chain reaction (PCR), or fluorescence in situ hybridization (FISH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of adenosine deaminase deficiency (ADA) with Severe Combined Immunodeficiency (SCID) phenotype confirmed by one of the following: A. Deficiency of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus (less than1% of normal) B. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compared to laboratory standard C. Decrease in ATP concentration in erythrocytes D. Molecular genetic confirmation of mutations in both alleles of the ADA1 gene E. Positive screening by T cell receptor excision circles (TRECs) 2. Not a candidate for or has failed bone marrow transplantation (BMT) 3. Platelets greater than 50,000cell/microL 4. Reauthorization A. The patient has experienced improvement in their plasma ADA activity, red blood cell dATP levels, immune function, and/or red blood cell dAXP levels

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

REVLIMID

MEDICATION(S)
LENALIDOMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For Multiple Myeloma dx:
    a. Used in combination with dexamethasone, OR
    b. As maintenance following autologous hematopoietic stem cell transplantation (auto HSCT)

2. For MCL:
    a. Pt has previous trial on bortezomib AND pt has trial on at least ONE other previous therapy

3. For transfusion-dependent anemia due to myelodysplastic syndrome
    a. Low or imitediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities

4. For follicular lymphoma and Marginal zone lymphoma (MZL)
    a. Used in combination with a rituximab product

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

REVUFORJ

MEDICATION(S)
REVUFORJ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Patients with an 11q23 partial tandem duplication 2. Active acute promyelocytic leukemia 3. Concomitant use with strong CYP3A4 inducers

REQUIRED MEDICAL INFORMATION
1. Diagnosis of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation
2. Diagnosis of relapsed or refractory acute myeloid leukemia with a susceptible nucleophosmin 1 (NPM1) mutation and no satisfactory alternative treatment options
a. For patients age 18 years and older, medical rationale for why Komzifti is not an acceptable alternative

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

REXULTI

MEDICATION(S)

REXULTI

PENDING CMS APPROVAL

REZDIFFRA

MEDICATION(S)

REZDIFFRA

PENDING CMS APPROVAL

REZLIDHIA

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of relapsed or refractory AML 2. Confirmed IDH-1 mutation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RINVOQ

MEDICATION(S)

RINVOQ, RINVOQ LQ

PENDING CMS APPROVAL

RIOCIGUAT

MEDICATION(S)

ADEMPAS, RIOCIGUAT

PENDING CMS APPROVAL

ROMVIMZA

MEDICATION(S)
ROMVIMZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT)
2. Patient is not a surgical candidate
3. Reason of medical necessity or contraindication/intolerance to the use of pexidartinib (Turalio)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ROZLYTREK

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of non-small cell lung cancer A. Has reactive oxygen species 1 positive 2. Diagnosis of Neurotrophic receptor tyrosine kinase-positive solid tumors A. Tumor is metastatic or surgical resection likely to result in severe morbidity B. Progression following previous treatment or there is not an adequate alternative treatment 3. For the oral pellets: patient has inability to swallow capsules and solution made from capsules.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUBRACA

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of deleterious BRACAmuation (germline and/or somatic)-associated recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer
   a. Used for maintenance treatment as monotherapy
   b. Have a complete or partial response to platinum-based chemotherapy
2. Diagnosis of deleterious BRACAmutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC)
   a. Previously treated with androgen receptor-directed therapy
   b. Used as monotherapy
3. Reason of medical necessity or contraindication/intolerance to the use of olaparib (Lynparza)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

RYDAPT

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Used for post-consolidation therapy (maintenance) for dx of AML

REQUIRED MEDICAL INFORMATION
1. For AML dx: a. Cancer is FLT3 mutation positive 2. Dx of systemic mastocytosis a. Systemic mastocytosis is identified as aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SABRIL

MEDICATION(S)
VIGABATRIN 500 MG TAB, VIGAFYDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For infantile spasms (solution only)

a. Must be used as monotherapy

2. For refractory complex partial seizures

a. For oral solution requests, patient has inability to swallow tablets

b. Must be used as adjunctive therapy,

c. Must have tried at least TWO of the following:

i. Rufinamide,

ii. Carbamazepine,

iii. Celontin,

iv. Dilantin,

v. Divalproex,

vi. Epitol,

vii. Equetro,

viii. Ethosuximide,

ix. Felbamate,

x. Tiagabine,

xi. Lamictal,

xii. Lamotrigine,

xiii. Levetiracetam,

xiv. Pregabalin,

xv. Primidone,

xvi. Oxcarbazepine,

xvii. Phenytoin,

xviii. Topiramate,

xix. Valproic Acid,

xx. Lacosamide,

xxi. Zonisamide

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SAPROPTERIN

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of hyperphenylalaninemia due to tetra hydrobiopterin- (BH4-) responsive Phenylketonuria

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SCEMBLIX

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP)
2. Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP):
   a. Patient has previous failure, intolerance, or contraindication to dasatinib
3. Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) with T315I mutation:
   a. Documentation of testing for mutation
   b. Must try and fail ponatinib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

SEMAGLUTIDE

MEDICATION(S)
OZEMPIC, OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Type 1 diabetes mellitus

REQUIRED MEDICAL INFORMATION
Diagnosis of Type 2 diabetes mellitus (T2DM)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SIGNIFOR

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For Cushing's: a. Pt is NOT a candidate for pituitary surgery, b. If pt previously had pituitary surgery: Pt continues to have high 24-hour urinary free cortisol levels c. Patient has tried at least one of the following: i. ketoconazole ii. metyrapone 2. For acromegaly a. Pt has had surgical resection of the pituitary gland OR is not a candidate for surgery/radiation therapy b. Pt has tried at least one of the following: i. bromocriptine ii. cabergoline iii. octreotide acetate c. Pt has tried at least one of the following: octreotide depot or lanreotide

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: Plan year Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

SILDENAFIL PAH

MEDICATION(S)
SILDENAFIL CITRATE 10 MG/ML RECON SUSP, SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial: a. Pt is diagnosed with pulmonary arterial hypertension, confirmed by right heart catheterization b. Pt with positive vasoreactivity test: i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers, c. For sildenafil oral suspension requests: Inability to swallow tablets 2. Reauth: a. Pt has been reassessed within the past 6 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SIRTURO

MEDICATION(S)

SIRTURO

PENDING CMS APPROVAL

SOMAVERT

MEDICATION(S)

SOMAVERT

PENDING CMS APPROVAL

STELARA

MEDICATION(S)

USTEKINUMAB 45 MG/0.5ML SOLN PRSYR, USTEKINUMAB 45 MG/0.5ML SOLUTION, USTEKINUMAB 90 MG/ML SOLN PRSYR

PENDING CMS APPROVAL

STIVARGA

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of metastatic colorectal cancer (CRC)
A. Patient has been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type, an anti-EGFR therapy.
2. Diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST)
A. Patient has been previously treated with imatinib mesylate and sunitinib malate.
3. Diagnosis of hepatocellular carcinoma (HCC)
A. Patient has been previously treated with sorafenib

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

SUTENT

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Sutent used as combination therapy with other chemotherapies

REQUIRED MEDICAL INFORMATION
1. Treatment of adult patients with gastrointestinal stromal tumor (GIST)

a. Patient had disease progression on or intolerance to imatinib mesylate.

2. Treatment of adult patients with advanced renal cell carcinoma (RCC).

3. Adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy.

4. Treatment of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in adult patients with unresectable locally advanced or metastatic disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SYNAREL

MEDICATION(S)
SYNAREL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pt has previous trial on leuprolide acetate

AGE RESTRICTION
1. For CPP: Treatment initiated at or before 8 years of age in girls and 9 years of age in boys 2. For Endometriosis: 18 years old or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SYPRINE

MEDICATION(S)
TRIENTINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has failure on penicillamine,

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TABLOID

MEDICATION(S)
TABLOID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Use for chronic lymphocytic leukemia, Hodgkins lymphoma, multiple myeloma, or solid tumors
2. Use in patients whose disease has demonstrated prior resistance to thioguanine

REQUIRED MEDICAL INFORMATION
1. Diagnosis of a. Acute Myeloid Leukemia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TABRECTA

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of metastatic non-small cell lung cancer (NSCLC) 2. Tumor mutation leading to mesenchymal-epithelial transition (MET) exon 14 skipping

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TADALAFIL

MEDICATION(S)
TADALAFIL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Benign Prostatic Hypertrophy (BPH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TADALAFIL PAH

MEDICATION(S)
TADALAFIL (PAH), TADLIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial: a. Pt is diagnosed with pulmonary arterial hypertension, confirmed by right heart catheterization b. Pt with positive vasoreactivity test: i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers, c. For Tadliq requests: Inability to swallow tablets 2. Reauth: a. Pt has been reassessed within the past 6 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TAFINLAR

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)For unresectable or metastatic melanoma dx: a)Pt is BRAF (V600E or V600K) mutation positive 2)For adjuvant treatment of melanoma dx: a)Pt is BRAF (V600E or V600K) mutation positive b)Pt has failed Opdivo OR Keytruda 3)For metastatic NSCLC dx: a)Pt is BRAF V600E positive 4)For Locally Advanced or Metastatic Anaplastic Thyroid Cancer dx: a)Pt is BRAF V600E positive with no satisfactory locoregional treatment options 5)For Unresectable or Metastatic Solid Tumors dx: a)Pt is BRAF V600E positive and has progressed following prior treatment and have no satisfactory alternative treatment options 6)For Low-Grade Glioma dx a)Pt is BRAF V600E mutation positive and requires systemic therapy b) Reason of medical necessity or contraindication/intolerance to the use of vemurafenib (Zelboraf) 7)For Tafinlar tablets for oral suspension: Member has inability to swallow capsules

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TAGRISSO

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) and will be used as one of the following:

a. adjuvant therapy after tumor resection, whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations
b. locally advanced, unresectable (stage III) NSCLC whose disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy and whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations
c. first-line treatment of metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations
d. first-line treatment of locally advanced or metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations in combination with pemetrexed and platinum-based chemotherapy
e. treatment of adult patients with metastatic EGFR T790M mutation positive NSCLC, whose disease has progressed on or after EGFR TKI therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TALZENNA

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of HRR Gene-mutated mCRPC, in combination with enzalutamide (Xtandi) 2. Deleterious or suspected deleterious germline BRCA, HER2-negative locally advanced or metastatic breast cancer

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TARCEVA

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For NSCLC dx: a. Pt with EGFR mutation, b. Erlotinib is not used in combination with platinum-based chemotherapy, 2. For pancreatic cancer dx: a. Combination with gemcitabine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TARGRETIN

MEDICATION(S)
BEXAROTENE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. If female: Pt planning to become pregnant

REQUIRED MEDICAL INFORMATION
1. Capsules: a. Pt has previous failure on at least ONE of the following: i. Antineoplastic chemotherapy, ii. Interferon alfa and gamma, iii. Interleuking-12, iv. Interleukin-2, 2. Gel: a. Pt has previous failure on at least ONE of the following: i. PUVA, ii. UVB, iii. EVT, iv. Photophoresis, v. Systemic cytotoxic chemotherapy, vi. Topical nitrogen mustard, vii. Topical carmustine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TARPEYO

MEDICATION(S)
TARPEYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of biopsy verified primary immunoglobulin A (IgA) nephropathy
   A. Proteinuria defined as a urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.5 g/day

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescriber is a nephrologist

COVERAGE DURATION
For Tarpeyo: 9 months, no reauthorization

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TASIGNA

MEDICATION(S)
NILOTINIB HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
For Ph+ CML Dx: Pts who have BCR-ABL1 mutations T315I, Y253H, E255K/V, F359V/C/I, or G250E

REQUIRED MEDICAL INFORMATION
1. Adult or pediatric with newly diagnosed Philadelphia chromosome positive (Ph+) CML in chronic phase
2. Adult with chronic phase and accelerated phase Ph+ CML
   a. Patient has previous failure, intolerance, or contraindication to dasatinib
3. Pediatric patient with chronic phase or accelerated phase Ph+ CML

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TAVALISSE

MEDICATION(S)

TAVALISSE

PENDING CMS APPROVAL

TAVNEOS

MEDICATION(S)
TAVNEOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Patient currently requires dialysis

REQUIRED MEDICAL INFORMATION
Initial: 1. Diagnosis of ANCA-associated vasculitis 2. ANCA-antibody titer test 3. Patient is currently receiving rituximab or cyclophosphamide Reauth: 1. Patient has experienced slowing of disease progression or disease stabilization

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauth: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TEPMETKO

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
2. A reason of medical necessity is provided why pt cannot use Tabrecta

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TERIPARATIDE

MEDICATION(S)

TERIPARATIDE

PENDING CMS APPROVAL

TESTOSTERONE

MEDICATION(S)
TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL, TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Male Hypogonadism: a. Hypogonadism confirmed by ONE of the following: i. At least 2 total serum testosterone levels of less than 300 ng/dL taken on separate occasions, OR ii. Free serum testosterone level of less than 5 ng/dL, 2. Male Delayed Puberty

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Hypogonadism: Plan Year, Delayed Puberty: 6 Months

OTHER CRITERIA
1. Patient 40 years of age or older: a. Initial: i. Prostate specific antigen (PSA) has been evaluated for prostate cancer screening, b. Renewal: i. PSA has been evaluated for prostate cancer screening AND ii. Patient shows improved symptoms compared to baseline and tolerance to treatment

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

TIBSOVO

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of:
a. Newly diagnosed AML in adults 75 years or older, or who have comorbidities that preclude the use of intensive induction chemotherapy and will be used either in combination with azacitadine or as monotherapy
b. Relapsed or refractory AML.
c. Relapsed or refractory myelodysplastic syndromes.
d. Locally advanced or metastatic cholangiocarcinoma who have been previously treated
2. Pt has IDH1 mutation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TIRZEPATIDE

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Type 1 diabetes mellitus

REQUIRED MEDICAL INFORMATION
Diagnosis of Type 2 diabetes mellitus (T2DM)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOBRAMYCIN

MEDICATION(S)
TOBRAMYCIN 300 MG/5ML NEBU SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has had at least ONE positive culture for Pseudomonas aeruginosa

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
BvsD

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIKAFTA

MEDICATION(S)

TRIKAFTA

PENDING CMS APPROVAL

TRUQAP

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Type 1 diabetes mellitus, OR Type 2 diabetes mellitus that is uncontrolled or requires insulin at baseline

REQUIRED MEDICAL INFORMATION
1. Dx of HR-positive, HER2-negative, locally advanced or metastatic breast cancer
   a. Patient has PIK3CA/AKT1/PTEN-alterations.
   b. Patient has failed at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy
   c. Truqap with be used in combination with fulvestrant
2. Diagnosis of metastatic prostate cancer
   a. Patient is andorgen pathway modulation-naive or -sensitive (mAPMN/S)
   b. Patient is PTEN-deficient
   c. Used in combination with abiraterone and prednisone

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TRYNGOLZA

MEDICATION(S)

TRYNGOLZA

PENDING CMS APPROVAL

TUKYSA

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases:

a. Pt has received one or more prior anti-HER2-based regimens in the metastatic setting

b. Tukysa will be used in combination with trastuzumab and capecitabine.

2. Diagnosis of RAS wild-type HER2-positive unresectable or metastatic colorectal cancer

a. Cancer has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy,

b. Tukysa will be used in combination with trastuzumab

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TURALIO

MEDICATION(S)
TURALIO 125 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A. Diagnosis of Tenosynovial Giant Cell Tumor B. Condition is associated with severe morbidity or functional limitations C. Surgery will NOT improve status

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TYENNE

MEDICATION(S)

AVTOZMA 162 MG/0.9ML SOLN A-INJ, AVTOZMA 162 MG/0.9ML SOLN PRSYR, TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

PENDING CMS APPROVAL

TYKERB

MEDICATION(S)
LAPATINIB DITOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For advanced or metastatic HER-2 positive breast cancer dx:
   a. Prior therapy with an anthracycline, taxane, and trastuzumab AND
   b. Combination therapy with capecitabine
2. For postmenopausal HER-2 receptor hormone receptor positive breast cancer dx:
   a. Combination therapy with letrozole

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TYMLOS

MEDICATION(S)

TYMLOS

PENDING CMS APPROVAL

UPTRAVI

MEDICATION(S)
UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial:
   a. If pt has a positive vasoreactivity test:
      i. Pt has failed maximum tolerated doses of calcium channel blockers,
   b. For adults, pt has previous trial on at least ONE of the following:
      i. ambrisentan, ii. bosentan iii. Opsumit iv. Riociguat (Adempas)
   c. For pediatric patients, pt has previous trial on sildenafil
2. Reauth:
   a. Pt has been reassessed within the past 6 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist or Cardiologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

USTEKINUMAB

MEDICATION(S)

PYZCHIVA 45 MG/0.5ML SOLN A-INJ, PYZCHIVA 45 MG/0.5ML SOLN PRSYR, PYZCHIVA 45 MG/0.5ML SOLUTION, PYZCHIVA 90 MG/ML SOLN A-INJ, PYZCHIVA 90 MG/ML SOLN PRSYR, SELARSDI 45 MG/0.5ML SOLN PRSYR, SELARSDI 45 MG/0.5ML SOLUTION, SELARSDI 90 MG/ML SOLN PRSYR

PENDING CMS APPROVAL

VALCHLOR

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has previous trial on at least ONE previous skin directed therapy of the following: a. Topical corticosteroid, b. Topical carmustine, c. Topical retinoid, d. Radiation therapy, e. Phototherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VANFLYTA

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Newly diagnosed acute myeloid leukemia that is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA approved test. 2. Will be taken in combination with standard cytarabine and anthracycline induction, cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VAXCHORA

MEDICATION(S)
VAXCHORA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Member is traveling to area of active cholera transmission 2. Member is between the ages of 2 and 64

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VELTASSA

MEDICATION(S)
VELTASSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial: a. If patient is on a ACE or ARB must meet BOTH of the following: i. Pt has been tried on a loop or thiazide diuretic or has a contraindication to one of these diuretics, ii. The dose of the ACE or ARB has been reduced in an attempt to lower serum potassium levels, b. Serum potassium levels above upper limit of normal on two separate screenings, c. If patient is 18 years or older: Pt has failed Lokelma

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VEMLIDY

MEDICATION(S)
VEMLIDY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pt has decompensated hepatic impairment

REQUIRED MEDICAL INFORMATION
Pt has previous trial on entecavir

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VENCLEXTA

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. For CLL/SLL dx 2. For AML dx: a. Pt is ineligible for induction therapy OR b. Pt is 75 years or older

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VEPDEGESTRANT

MEDICATION(S)

VEPPANU

PENDING CMS APPROVAL

VERQUVO

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Pregnancy

REQUIRED MEDICAL INFORMATION
1. Dx of chronic heart failure
   A. New York Heart Association class II-IV
   B. Left ventricular ejection fraction less than 45%
2. Previous hospitalization due to heart failure or previous outpatient IV diuretic treatment

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VERSACLOZ

MEDICATION(S)
VERSACLOZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone 2. For Schizophrenia: Previous trial on Vraylar

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VERZENIO

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Adjuvant treatment of HR-positive, HER-2 negative, node positive early breast cancer at high risk of recurrence in combination with tamoxifen or aromatase inhibitor 2. Dx of HR-positive, HER2-negative Advanced or Metastatic breast cancer: Must meet a, b, OR c of the following: a. Pt is receiving Verzenio in combination with an aromatase inhibitor as initial endocrine-based therapy b. Pt with disease progression following endocrine therapy in combination with fulvestrant, c. Pt with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

VIMKUNYA

MEDICATION(S)
VIMKUNYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Documentation that confirms that the patient is at increased risk of exposure to chikungunya virus

AGE RESTRICTION
12 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VITRAKVI

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of solid tumor with a neutrotrophis receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation
2. Are metastatic or where surgical resection is likely to result in severe morbidity
3. Have no satisfactory alternative treatments or that have progressed following treatment

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VIVOTIF

MEDICATION(S)
VIVOTIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Member meets one of the following:
   A. Traveling to an area with recognized risk of exposure to S. typhi
   B. Has intimate exposure to a S. typhi carrier
   C. a microbiology laboratorian frequently working with S. typhi
2. Member has not received vaccination for S. typhi in the last 5 years

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 Month

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VONJO

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of intermediate or high-risk primary or secondary myelofibrosis (MF)
   a. For secondary MF: post-polycythemia vera or post-essential thrombocythemia
2. Documentation showing platelet counts below 50,000/mm3 within the last 30 days
3. For intermediate risk: Inadequate response or intolerance to hydroxyurea, Pegasys, or Jakafi
4. For high risk: patient is not a candidate for transplant

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months Reauthorization: Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VORANIGO

MEDICATION(S)
VORANIGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Patient has Grade 2 oligodendroglioma or astrocytoma per WHO criteria
2.Patient has confirmed IDH1 or IDH2 gene mutation
3. Patient has had at least 1 prior surgery for glioma (biopsy, sub-total resection, gross-total resection)
4. One of:
  a. Patient has not received other prior anticancer therapy, including chemotherapy and radiotherapy
  b. Patient has received both RT and chemotherapy AND
    i. patient has KPS greater than or equal to 60
5. Patient has MRI evaluable, measurable, non-enhancing disease

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

VOSEVI

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Confirmation of genotype

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 Weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VOTRIENT

MEDICATION(S)
PAZOPANIB HCL 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Soft Tissue Sarcoma dx: a. Previous trial on at least ONE prior therapy 2. Advanced renal cell carcinoma dx

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VYNDAQEL

MEDICATION(S)

ATTRUBY

PENDING CMS APPROVAL

WEGOVY

MEDICATION(S)

WEGOVY

PENDING CMS APPROVAL

WELIREG

MEDICATION(S)

WELIREG

PENDING CMS APPROVAL

WINREVAIR

MEDICATION(S)
WINREVAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Diagnosis or pulmonary arterial hypertension WHO Groups 2, 3, 4, or 5
2. Diagnosis of the following PAH Group 1 subtypes: human immunodeficiency virus (HIV)-associated PAH, PAH associated with portal hypertension, schistosomiasis associated PAH, or pulmonary veno-occlusive disease

REQUIRED MEDICAL INFORMATION
1. Dx of pulmonary arterial hypertension (PAH), classified as WHO functional class (FC) II, III, or IV
2. Documented diagnostic right heart catheterization confirming the diagnosis of World Health Organization (WHO) pulmonary arterial hypertension (PAH) Group 1 in any of the following subtypes: a. Idiopathic PAH b. Heritable PAH c. Drug/Toxin-induced PAH d. PAH associated with connective tissue disorder e. PAH associated with simple, congenital tissue disease
3. Patient has undergone vasoreactivity testing and failed maximum tolerated doses of calcium channel blockers (if applicable)
4. Patient's current therapy consists of at least 2 of the following background PAH medications: PDE-5 inhibitor (tadalafil, sildenafil), endothelin receptor antagonist (ambrisentan, bosentan, Opsumit), prostacyclin agonist (treprostinil or epoprostenol, or selexipag).
6. Patient has a documented intolerance or disease progression on a two-drug regimen

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
Pulmonologist or Cardiologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

XALKORI

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx with:
  a. metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK) positive
    i. Reason of medical necessity or contraindication/intolerance to the use of alectinib (Alecensa)
  b. metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive
    i. Reason of medical necessity or contraindication/intolerance to the use of entrectinib (Rozlytrek)
  c. relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive
    i. Reason of medical necessity or contraindication/intolerance to the use of alectinib (Alecensa)
  d. unresectable, recurrent, or refractory ALK-positive inflammatory myofibroblastic tumor
    i. Reason of medical necessity or contraindication/intolerance to the use of alectinib (Alecensa)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

XDEMVY

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Demodex blepharitis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Ophthalmologist or Optometrist

COVERAGE DURATION
6 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XENAZINE

MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Tardive Dyskinesia

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of chorea due to Huntington's Disease OR 2. Diagnosis of Tardive Dyskinesia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XERMELO

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Initial:

a. Pt has more than 4 bowel movements a day despite treatment with sandostatin analog therapy for at least 3 months

b. Pt has previous trial of lomotil AND loperamide

c. Xermelo will be used in combination with ocretoide depot or lanreotide

2. Reauth:

a. Pt has experienced improvement in bowel movement frequency since starting Xermelo

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 Months

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

XIFAXAN

MEDICATION(S)

XIFAXAN

PENDING CMS APPROVAL

XOLAIR

MEDICATION(S)

XOLAIR

PENDING CMS APPROVAL

XOSPATA

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Relapsed or refractory AML 2. patient has a FLT3 mutation detected by an FDA-approved test

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XPOVIO

MEDICATION(S)
XPOVIO (100 MG ONCE WEEKLY), XPOVIO (40 MG ONCE WEEKLY), XPOVIO (40 MG TWICE WEEKLY), XPOVIO (60 MG ONCE WEEKLY), XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY), XPOVIO (80 MG TWICE WEEKLY)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of multiple myeloma:
   A. Patient has received at least one prior therapy
   B. Used in combination with bortezomib and dexamethasone
2. Diagnosis of relapsed or refractory multiple myeloma:
   A. Patient has received at least four prior therapies
   B. Patient's disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody
   C. Used in combination with dexamethasone

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

XTANDI

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of non-metastatic castration sensitive prostate cancer (nmCSPC)
   a. Patient has failed androgen deprivation therapy (ADT) with one of the following: orchiectomy, LHRH agonist (leuprolide, Lupron, Zoladex), LHRH antagonist (Firmagon)
2. Diagnosis of metastatic castration-sensitive prostate cancer (mCSPC)
   a. Patient has failed ADT and abiraterone 250mg
3. Diagnosis of castration-resistant prostate cancer (CRPC)
   a. For non-metastatic, has a PSA doubling time of less than or equal to 10 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

YONSA

MEDICATION(S)
YONSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1.Diagnosis of metastatic castration-resistant prostate cancer (mCRPC)
2. Will be used with methylprednisolone
3. Reason of medical necessity or contraindication/intolerance to the use of generic abiraterone 250mg

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZARXIO

MEDICATION(S)
NEUPOGEN, RELEUKO 300 MCG/0.5ML SOLN PRSYR, RELEUKO 480 MCG/0.8ML SOLN PRSYR, ZARXIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of:
   A. Neutropenia
   B. Autologous Peripheral Blood Progenitor Cell Collection and Therapy
   C. Hematopoietic Syndrome of Acute Radiation Syndrome
2. For Neutropenia: pt has trial on BOTH of the following: a. Nivestym, b. Granix
3. For Autologous Peripheral Blood Progenitor Cell Collection and Therapy: pt has trial on Nivestym

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ZEJULA

MEDICATION(S)
ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. First-Line Maintenance Treatment of HRD-Positive Advanced Ovarian Cancer
a. Pt has had complete or partial response to first-line platinum-based chemotherapy
b. Cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either:
i. a deleterious or suspected deleterious BRCA mutation, and/or
ii. genomic instability.
2. Maintenance Treatment of Recurrent Germline BRCA-Mutated Ovarian Cancer
a. Pt has had complete or partial response to platinum-based chemotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ZELBORAF

MEDICATION(S)

ZELBORAF

PENDING CMS APPROVAL

ZIDESAMTINIB

MEDICATION(S)
JIDEYTRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Diagnosis of Advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC)
2. Pt has experienced disease progression on at least one prior ROS1 kinase inhibitor
3. Patient has documented failure or contraindication/intolerance to repotrectinib (Augtyro) or taletrectinib (Ibtrozi)
4. Will be used as monotherapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZOLINZA

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Pt has progressive, persistent, or recurrent disease, 2. Pt has tried at least TWO prior systemic therapies

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZONISADE

MEDICATION(S)
ZONISADE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of partial-onset seizures 2. Inability to swallow tablets and capsules

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZTALMY

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Confirmation of CDKL5 deficiency based on genetic testing

AGE RESTRICTION
2 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZURZUVAE

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx of Postpartum Depression (PPD) 2. Major Depressive episode began in third trimester of pregnancy or within 4 weeks following delivery 3. Treatment will be initiated less than or equal to 12 months after delivery 4. Maximum duration 14 days per pregnancy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZYKADIA

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1. Dx with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZYMFENTRA

MEDICATION(S)

ZYMFENTRA (1 PEN), ZYMFENTRA (2 PEN), ZYMFENTRA (2 SYRINGE)

PENDING CMS APPROVAL