Moda Health Rx (PDP) Medicare Part D Plan

Prior Authorization Criteria
Last Updated 1/1/2026

Products Affected

- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 15mg odt (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: a) Member is unable to swallow aripiprazole tablet and b) Member is unable to use aripiprazole oral solution.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *tretinoin 0.01% topical gel*
- *tretinoin 0.025% topical gel*
- *tretinoin 0.1% topical cream*
- *tretinoin 0.025% topical cream*
- *tretinoin 0.05% topical cream*

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

Products Affected

– ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

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

Products Affected

- *alyq 20mg tab*
- *tadalafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension: Both of the following were ineffective or not tolerated: one endothelial receptor antagonist (ambrisentan, bosentan or macitentan (Opsumit)) and one phosphodiesterase-5 inhibitor (sildenafil or tadalafil). For persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4): Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *everolimus 10mg tab (New Starts Only)*
- *everolimus 2mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab (New Starts Only)*
- *everolimus 7.5mg tab (New Starts Only)*
- *everolimus 2.5mg tab (New Starts Only)*
- *everolimus 3mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab for oral susp (New Starts Only)*

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

Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For migraine prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. For migraine prevention (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- AKEEGA 500-100MG TAB (New Starts Only)
- AKEEGA 500-50MG TAB (New Starts Only)

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

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

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

Products Affected

– *nitazoxanide 500mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For diarrhea due to giardiasis: One of the following was ineffective or not tolerated: a) metronidazole or b) tinidazole. For diarrhea due to cryptosporidiosis: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– PROLASTIN 1000MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: 1) Diagnosis of congenital alpha1-antitrypsin deficiency is confirmed by both of the following: A) circulating baseline alpha1-antitrysin level is below the standard protective threshold (less than 11 micromol/L or less than 50 mg per deciliter by nephelometry) and B) high risk alpha1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) and 2) Prescriber attests that member does not have IgA deficiency with known anti-IgA antibody.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a pulmonologist
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)
- ALUNBRIG TAB INITIATION PACK (30) (New Starts Only)

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

Products Affected

- ALYFTREK 125-50-10MG TAB
- ALYFTREK 50-20-4MG TAB

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

Products Affected

- *eslicarbazepine acetate 200mg tab (New Starts Only)*
- *eslicarbazepine acetate 400mg tab (New Starts Only)*
- *eslicarbazepine acetate 600mg tab (New Starts Only)*
- *eslicarbazepine acetate 800mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ARCALYST 220MG INJ

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

Products Affected

– ARIKAYCE 590MG/8.4ML INH SUSP

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

Products Affected

– ATTRUBY 356MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM)(initial requests): Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive Congo Red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining or B) Non-invasive testing demonstrating all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65, ii) Absence of monoclonal protein via serum protein immunofixation, iii) Absence of monoclonal protein via urine protein immunofixation and iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For ATTR-CM (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For ATTR-CM: Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of ATTR-CM.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For ATTR-CM (all requests): Will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra) or tafamidis (Vyndaqel/Vyndamax).

Products Affected

- AUGTYRO 160MG CAP (New Starts Only)
- AUGTYRO 40MG CAP (New Starts Only)

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

Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 30MG ER TAB
- AUSTEDO 36MG ER TAB
- AUSTEDO 42MG ER TAB
- AUSTEDO 48MG ER TAB
- AUSTEDO 6MG TAB
- AUSTEDO 9MG TAB
- AUSTEDO XR 12MG TAB
- AUSTEDO XR 18MG TAB
- AUSTEDO XR 24MG TAB
- AUSTEDO XR 6MG TAB
- AUSTEDO XR TAB ONCE DAILY 4 WEEK TITRATION PACK (28)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy or ii) Member is unable to switch current antidopaminergic therapy or iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy and B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– AUVELITY 105-45MG ER TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, or j) duloxetine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– AVMAPKI/FAKZYNJA CO-PACK (66) (New Starts Only)

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

Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 25MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)

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

Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 4MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

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

Products Affected

- *rufinamide 200mg tab (New Starts Only)*
- *rufinamide 400mg tab (New Starts Only)*
- *rufinamide 40mg/ml oral susp (New Starts Only)*

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

Products Affected

- BENLYSTA 200MG/ML AUTO-INJECTOR
- BENLYSTA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For systemic lupus erythematosus initial requests: Two of the following were ineffective or not tolerated: a) hydroxychloroquine, b) methotrexate, c) azathioprine, d) mycophenolate or e) a corticosteroid. For all requests: Prescriber attests that member does not have severe active CNS lupus and member is not taking other biologics. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a rheumatology specialist, nephrologist, or dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL or B) low complement (C3/C4) or C) positive for anti-Smith antibodies. For systemic lupus erythematosus (all requests): Will not be given in combination with other biologics. For active lupus nephritis (all requests): Will not be used in combination with voclosporin (Lupkynis).

Products Affected

– BESREMI 500MCG/ML SYRINGE (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polycythemia vera: One of the following: A) Both of the following: i) High risk disease as defined by one of the following: a) Age 60 years or older or b) History of thrombosis and ii) Trial of hydroxyurea was ineffective, contraindicated, or not tolerated or B) Both of the following: i) Low risk as defined by both of the following: a) Age less than 60 years and b) No history of thrombosis.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- BOMYNTRA 120MG/1.7ML INJ
- BOMYNTRA 120MG/1.7ML SYRINGE

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

Products Affected

- BOSULIF 100MG CAP (New Starts Only)
- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 400MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)
- BOSULIF 50MG CAP (New Starts Only)

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

Products Affected

– BRAFTOVI 75MG CAP (New Starts Only)

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

Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– BRUKINSA 80MG CAP (New Starts Only)

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

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

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

Products Affected

- *calcipotriene 0.005% topical cream*
- *calcipotriene 0.005% topical ointment*
- CALCIPOTRIENE 0.005% TOPICAL SOLN

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

Products Affected

– CALQUENCE 100MG TAB (New Starts Only)

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

Products Affected

- CAPLYTA 10.5MG CAP (New Starts Only)
- CAPLYTA 21MG CAP (New Starts Only)
- CAPLYTA 42MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine. For bipolar depression: Two of the following were ineffective or not tolerated: a) lurasidone, b) quetiapine, or c) asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- CAPRELSA 100MG TAB (New Starts Only)
- CAPRELSA 300MG TAB (New Starts Only)

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

Products Affected

– *carglumic acid 200mg tab for oral susp*

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

Products Affected

– CAYSTON 75MG/ML INH SOLN

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

Products Affected

- *tadalafil 2.5mg tab*
- *tadalafil 5mg tab*

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

Products Affected

- CIMZIA 200MG INJ
- CIMZIA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel c) Rinvoq, d) Xeljanz or e) Tyenne. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Rinvoq, or e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Stelara or Steqeyma, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq or i) Xeljanz. For plaque psoriasis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Skyrizi, e) Stelara or Steqeyma, f) Tremfya or g) Otezla. For Crohn's disease (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Stelara or Steqeyma, c) Skyrizi, d) Rinvoq, or e) Tremfya. For Non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Xeljanz, d) Rinvoq, or e) Tyenne. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, non-radiographic axial spondyloarthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn's disease: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COBENFY 20-100MG CAP (New Starts Only)
- COBENFY 20-50MG CAP (New Starts Only)
- COBENFY 30-125MG CAP (New Starts Only)
- COBENFY CAP 28-DAY STARTER KIT PACK (56) (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COMETRIQ CAP 100MG DAILY DOSE PACK (56) (New Starts Only)
- COMETRIQ CAP 140MG DAILY DOSE PACK (112) (New Starts Only)
- COMETRIQ CAP 60MG DAILY DOSE PACK (84) (New Starts Only)

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

Products Affected

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

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

Products Affected

- *ivabradine 5mg tab*
- *ivabradine 7.5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For adults (18 years and older), one of the following: A) Member is on a maximally tolerated dose of beta blocker or B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- COSENTYX 150MG/ML AUTO-INJECTOR
- COSENTYX 150MG/ML SYRINGE
- COSENTYX 75MG/0.5ML SYRINGE
- COSENTYX UNOREADY 300MG/2ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For ankylosing spondylitis (all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts and b) Trial of one oral antibiotic was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis, non-radiographic axial spondyloarthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

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

Products Affected

- CRESEMBA 186MG CAP
- CRESEMBA 74.5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	For invasive aspergillosis: 3 months. For invasive mucormycosis: 6 months.
Other Criteria	

Products Affected

– CYSTADROPS 0.37% OPHTH SOLN

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

Products Affected

– *pyrimethamine 25mg tab*

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

Products Affected

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

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

Products Affected

– *metyrosine 250mg cap*

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- DOPTELET 20MG TAB
- DOPTELET TAB 40MG DAILY DOSE PACK (10)
- DOPTELET TAB 60MG DAILY DOSE PACK (15)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter. For chronic immune thrombocytopenia initial requests: Both of the following: A) Relapsed or refractory to at least one prior treatment for chronic immune thrombocytopenia B) Platelet count less than 30,000 platelets per microliter. For chronic immune thrombocytopenia continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For chronic immune thrombocytopenia: Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- DRIZALMA 20MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 30MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 40MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 60MG DR SPRINKLE CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Member is unable to swallow solid dosage forms of duloxetine (Cymbalta equivalent). For major depressive disorder and generalized anxiety disorder: One of the following was ineffective or not tolerated: 1) citalopram oral solution, 2) escitalopram oral solution, 3) fluoxetine oral solution, 4) paroxetine oral suspension, or 5) sertraline oral solution. For diabetic peripheral neuropathy and fibromyalgia: One of the following was ineffective or not tolerated: 1) gabapentin oral solution or 2) pregabalin oral solution. For chronic musculoskeletal pain: Trial of additional agents (other than duloxetine [Cymbalta equivalent]) not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) A medium to very high potency topical steroid, b) A topical calcineurin inhibitor or c) An oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For asthma (initial requests): History within the last year of at least one asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) Treatment with systemic corticosteroids, b) Emergency department visit or c) Hospitalization. For nasal polyps (initial requests): Trial of a nasal corticosteroid was ineffective or not tolerated. For eosinophilic esophagitis (initial requests): Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis (initial requests): Trial of other agents not required. For chronic obstructive pulmonary disease (COPD)(initial requests): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving optimized (triple therapy) maintenance therapy. For chronic spontaneous urticaria (initial requests): One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For atopic dermatitis, prurigo nodularis, or chronic spontaneous urticaria: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For asthma or COPD: Prescribed by, or in consultation with, an allergist, pulmonologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Prescribed by, or in consultation with, an allergist or gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) Body surface area involvement of 10 percent or more or b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas and 2) At least two of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For asthma (initial requests): One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter or 2) Oral corticosteroid-dependent asthma. For nasal polyps (initial requests): All of the following: a) Diagnosis of chronic

	rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis (initial requests): Both of the following: 1) Endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) and 2) Symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis (initial requests): Both of the following apply: a) Diagnosis has persisted for at least 6 weeks and b) Nodules present at baseline. For COPD (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For all atopic dermatitis, asthma, prurigo nodularis, or COPD (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For migraine prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. For episodic cluster headache prophylaxis initial requests: Trial of verapamil was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- EMSAM 12MG/24HR PATCH (New Starts Only)
- EMSAM 6MG/24HR PATCH (New Starts Only)
- EMSAM 9MG/24HR PATCH (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, or j) duloxetine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For juvenile psoriatic arthritis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, juvenile psoriatic arthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *glutamine 5000mg powder for oral soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: One of the following: 1) Both of the following: A) Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated and B) Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable) or 2) Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– SOFOSBUVIR/VELPATASVIR 400-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	All of the following: 1) Current HCV-RNA titer is provided, 2) One of the following: a) Member does not have cirrhosis or b) Member has compensated cirrhosis and one of the following: i) Does not have genotype 3 or ii) has genotype 3 but no NS5A resistance-associated substitution Y93H, or c) Member has decompensated cirrhosis and will receive weight-based ribavirin.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Products Affected

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

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

Products Affected

– *topiramate 25mg/ml oral soln (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of topiramate.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, headache specialist, or pain specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

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

Products Affected

- ERLEADA 240MG TAB (New Starts Only)
- ERLEADA 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *pirfenidone 267mg cap*
- *pirfenidone 267mg tab*
- *pirfenidone 801mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For idiopathic pulmonary fibrosis (initial requests): Diagnosis confirmed by one of the following: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP. For idiopathic pulmonary fibrosis (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For idiopathic pulmonary fibrosis: Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For idiopathic pulmonary fibrosis (all requests): Will not be used in combination with other agents for the prescribed indication.

Products Affected

– EUCRISA 2% TOPICAL OINTMENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For atopic dermatitis: One of the following was ineffective or not tolerated: a) A topical corticosteroid or b) A topical calcineurin inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- FASENRA 10MG/0.5ML SYRINGE
- FASENRA 30MG/ML AUTO-INJECTOR
- FASENRA 30MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma (initial requests): History within the last year of at least one asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit or c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA)(initial requests): Trial of oral corticosteroid therapy was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For asthma: Prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist. For EGPA: Prescribed by, or in consultation with, a rheumatology specialist, allergist, pulmonologist, or immunologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- FETZIMA 120MG ER CAP (New Starts Only)
- FETZIMA 20MG ER CAP (New Starts Only)
- FETZIMA 40MG ER CAP (New Starts Only)
- FETZIMA 80MG ER CAP (New Starts Only)
- FETZIMA ER CAP TITRATION PACK (28) (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, or j) duloxetine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- FRUZAQLA 1MG CAP (New Starts Only)
- FRUZAQLA 5MG CAP (New Starts Only)

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

Products Affected

- FYCOMPA 0.5MG/ML ORAL SUSP (New Starts Only)
- *perampanel 10mg tab (New Starts Only)*
- *perampanel 12mg tab (New Starts Only)*
- *perampanel 2mg tab (New Starts Only)*
- *perampanel 4mg tab (New Starts Only)*
- *perampanel 6mg tab (New Starts Only)*
- *perampanel 8mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For partial-onset seizures: Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide. For primary generalized tonic-clonic seizures: Two of the following were ineffective or not tolerated: a) lamotrigine, b) levetiracetam, c) primidone or d) topiramate.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– GAVRETO 100MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- GOMEKLI 1MG CAP (New Starts Only)
- GOMEKLI 2MG CAP (New Starts Only)
- GOMEKLI 1MG TAB FOR ORAL SUSP (New Starts Only)

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

Products Affected

- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 15MG/1.5ML PEN INJ
- NORDITROPIN 30MG/3ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ
- OMNITROPE 10MG/1.5ML CARTRIDGE
- OMNITROPE 5.8MG INJ
- OMNITROPE 5MG/1.5ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- HADLIMA 40MG/0.4ML AUTO-INJECTOR
- HADLIMA 40MG/0.8ML AUTO-INJECTOR
- HADLIMA 40MG/0.4ML SYRINGE
- HADLIMA 40MG/0.8ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin. For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts and b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid and b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist or ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- HAEGARDA 2000UNIT INJ
- HAEGARDA 3000UNIT INJ
- *icatibant 30mg/3ml syringe*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an allergist or immunologist
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For medications indicated for long-term prophylaxis (all requests): Will not be used in combination with another agent for long-term prophylaxis of hereditary angioedema attacks.

Products Affected

– HERNEXEOS 60MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

– IBTROZI 200MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– IMKELDI 80MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of imatinib.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– IMPAVIDO 50MG CAP

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

Products Affected

– INCRELEX 40MG/4ML INJ

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

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 60MG CAP
- INGREZZA 80MG CAP
- INGREZZA CAP THERAPY PACK (28)
- INGREZZA 40MG SPRINKLE CAP
- INGREZZA 60MG SPRINKLE CAP
- INGREZZA 80MG SPRINKLE CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy or ii) Member is unable to switch current antidopaminergic therapy or iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy and B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist or psychiatrist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

– INQOVI 35-100MG TAB PACK (5) (New Starts Only)

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

Products Affected

– INREBIC 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Jakafi was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

- ITOVEBI 3MG TAB (New Starts Only)
- ITOVEBI 9MG TAB (New Starts Only)

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

Products Affected

– *ivermectin 3mg tab*

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

Products Affected

- GAMMAGARD 10GM INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAGARD 5GM INJ
- GAMUNEX 1GM/10ML INJ
- PRIVIGEN 20GM/200ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

– IWILFIN 192MG TAB (New Starts Only)

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

Products Affected

- *deferasirox 180mg tab*
- *deferasirox 360mg tab*
- *deferasirox 90mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a hematologist
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- KALYDECO 13.4MG ORAL GRANULES
- KALYDECO 25MG ORAL GRANULES
- KALYDECO 50MG ORAL GRANULES
- KALYDECO 150MG TAB
- KALYDECO 5.8MG ORAL GRANULES
- KALYDECO 75MG ORAL GRANULES

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

Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB
- KERENDIA 40MG TAB

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

Products Affected

- KISQALI TAB 200MG DAILY DOSE PACK (21) (New Starts Only)
- KISQALI TAB 400MG DAILY DOSE PACK (42) (New Starts Only)
- KISQALI TAB 600MG DAILY DOSE PACK (63) (New Starts Only)
- KISQALI/FEMARA 400 CO-PACK (70) (New Starts Only)
- KISQALI/FEMARA 600 CO-PACK (91) (New Starts Only)

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

Products Affected

– *mifepristone 300mg tab*

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

Products Affected

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

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

Products Affected

– KRAZATI 200MG TAB (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Initial approval of 3 months. Continuing therapy approved for 1 year.
Other Criteria	

Products Affected

- LAZCLUZE 240MG TAB (New Starts Only)
- LAZCLUZE 80MG TAB (New Starts Only)

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

Products Affected

- LENVIMA 10MG DAILY DOSE PACK (30) (New Starts Only)
- LENVIMA 12MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 14MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 18MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 20MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 24MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 4MG DAILY DOSE PACK (30) (New Starts Only)
- LENVIMA 8MG DAILY DOSE PACK (60) (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *lidocaine 5% patch*
- *lidocan 5% patch*

PA Criteria	Criteria Details
Covered Uses	All Medically-accepted Indications.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *lidocaine 5% topical ointment*

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

Products Affected

– LITFULO 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For alopecia areata (initial requests): Hair loss impacts 50% or greater of the scalp. For alopecia areata (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For alopecia areata: Prescribed by or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– LIVTENCITY 200MG TAB

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- LUMAKRAS 120MG TAB (New Starts Only)
- LUMAKRAS 240MG TAB (New Starts Only)
- LUMAKRAS 320MG TAB (New Starts Only)

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

Products Affected

- LUMRYZ 4.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 6GM GRANULES FOR ORAL SUSP
- LUMRYZ 7.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 9GM GRANULES FOR ORAL SUSP
- LUMRYZ GRANULES FOR ORAL SUSP 28-DAY STARTER PACK (28

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi and b) either modafinil or armodafinil. Trial of other agents not required for patients aged 7 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For excessive daytime sleepiness with narcolepsy: A nocturnal polysomnogram was used to confirm diagnosis. For cataplexy with narcolepsy: One of the following was used to confirm diagnosis: a) nocturnal polysomnogram or b) low cerebrospinal fluid orexin-A concentration.

Products Affected

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

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

Products Affected

- LYTGOBI TAB 12MG DAILEY DOSE PACK (21) (New Starts Only)
- LYTGOBI TAB 16MG DAILEY DOSE PACK (28) (New Starts Only)
- LYTGOBI TAB 20MG DAILEY DOSE PACK (35) (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) For prior treatment with a sofosbuvir-based regimen, all of the following: i) Member does not have genotype 3 and ii) No prior treatment with an NS5A inhibitor plus NS3/4A protease inhibitor regimen.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Products Affected

- MEGESTROL ACETATE 125MG/ML ORAL SUSP
- *megestrol acetate 40mg/ml oral susp*

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

Products Affected

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

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

Products Affected

- MEKINIST 0.05MG/ML ORAL SOLN (New Starts Only)
- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

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

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

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

Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For acute treatment of migraine: Trial of two different triptans was ineffective or not tolerated. Trial of triptans not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders. Trial of second triptan not required for patients who did not tolerate initial triptan therapy.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– MODEYSO 125MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

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

Products Affected

- *acetylcysteine 100mg/ml inh soln*
- *acetylcysteine 200mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol 1.25mg/3ml neb soln*
- *albuterol 5mg/ml (0.5%) inh soln*
- AMPHOTERICIN B 50MG INJ
- *amphotericin b liposomal 50mg inj*
- *aprepitant 125mg cap*
- *aprepitant 125mg/80mg cap therapy pack (3)*
- *aprepitant 40mg cap*
- *aprepitant 80mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- *azathioprine 50mg tab*
- *budesonide 0.25mg/2ml inh susp*
- *budesonide 0.5mg/2ml inh susp*
- *budesonide 1mg/2ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX 5/20 INJ
- *clinisol 15% inj*
- *cromolyn sodium 10mg/ml inh soln*
- *cyclophosphamide 25mg cap*
- CYCLOPHOSPHAMIDE 25MG TAB
- *cyclophosphamide 50mg cap*
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 100mg cap*
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 25mg cap*
- *cyclosporine modified 50mg cap*
- DEXTROSE 10% INJ
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML INJ
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS XR 0.75MG TAB
- ENVARSUS XR 1MG TAB
- ENVARSUS XR 4MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.5mg tab*
- *everolimus 0.75mg tab*
- *everolimus 1mg tab*
- FIASP 100UNIT/ML INJ
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- *granisetron 1mg tab*
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- HUMULIN R 500UNIT/ML INJ
- IMOVAX 2.5UNIT/ML INJ
- INSULIN LISPRO 100UNIT/ML INJ
- *ipratropium bromide 0.02% inh soln*
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- JYNNEOS 0.5ML INJ
- *methylprednisolone 16mg tab*
- *methylprednisolone 32mg tab*

- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml oral susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 3mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TENIVAC 4-10UNIT/ML INJ
- TPN ELECTROLYTES INJ
- XATMEP 2.5MG/ML ORAL SOLN
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 300mg/6ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 5mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML INJ
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML SYRINGE
- TRAVASOL 10% INJ

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

Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

Products Affected

– NEMLUVIO 30MG AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) A medium to very high potency topical steroid, b) A topical calcineurin inhibitor or c) An oral immunosuppressant. For prurigo nodularis (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For atopic dermatitis or prurigo nodularis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) Body surface area involvement of 10 percent or more or b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas and 2) At least two of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For prurigo nodularis (initial requests): Both of the following apply: a) Diagnosis has persisted for at least 6 weeks and b) Nodules present at baseline. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

– NERLYNX 40MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

- NEXLETOL 180MG TAB
- NEXLIZET 180-10MG TAB

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– *posaconazole 100mg dr tab*

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

Products Affected

– NUBEQA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic hormone-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For non-metastatic castration-resistant prostate cancer: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma (initial requests): History within the last year of at least one asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit or c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA)(initial requests): Trial of oral corticosteroid therapy was ineffective or not tolerated. For hypereosinophilic syndrome (HES)(initial requests): Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter and B) Hypereosinophilic syndrome has persisted for at least six months. For nasal polyps (initial requests): Trial of a nasal corticosteroid was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For all indications, must be prescribed by, or in consultation with, one of the specialists listed. For asthma: Allergist, pulmonologist, or immunologist. For nasal polyps: Allergist, immunologist, or otolaryngologist. For EGPA: Rheumatology specialist, allergist, pulmonologist, or immunologist. For HES: Rheumatology specialist, allergist, pulmonologist, gastroenterologist, hematologist, or other specialist experienced in the diagnosis and treatment of HES.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For nasal polyps (initial requests): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

– NUEDEXTA 20-10MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect. For continuation requests, both of the following: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect and B) Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

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

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

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

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

Products Affected

- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For idiopathic pulmonary fibrosis (initial requests): Both of the following: 1) Diagnosis confirmed by one of the following: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP and 2) Trial of pirfenidone was ineffective or not tolerated. For systemic sclerosis-associated interstitial lung disease (ILD) (initial requests): All of the following: 1) Diagnosis confirmed with documentation provided of both of the following: A) HRCT scan and B) pulmonary function tests, 2) Trial of mycophenolate mofetil was ineffective or not tolerated and 3) Trial of Tyenne was ineffective or not tolerated. For chronic fibrosing ILDs with a progressive phenotype (initial requests): All of the following: 1) Disease is progressive, as defined by one of the following over the past 12 months, with no alternative explanation: A) Worsening respiratory symptoms, B) One of the following: i) Forced vital capacity (FVC) decline of 5% or more or ii) Absolute decline in, and diffusing capacity of, the lung for carbon monoxide (corrected for hemoglobin) of 10% predicted or greater or C) Radiological evidence of disease progression and 2) Progression occurred despite treatment with one of the following: i) azathioprine, ii) cyclosporine, iii) mycophenolate mofetil, iv) tacrolimus, v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide, or vii) rituximab. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For idiopathic pulmonary fibrosis and chronic fibrosing ILDs with a progressive phenotype: Prescribed by, or in consultation with, a pulmonologist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist or rheumatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For idiopathic pulmonary fibrosis (all requests): Will not be used in combination with other agents for the prescribed indication.

Products Affected

- OGSIVEO 100MG TAB 7-DAY PACK (14) (New Starts Only)
- OGSIVEO 150MG TAB 7-DAY PACK (14) (New Starts Only)
- OGSIVEO 50MG TAB (New Starts Only)

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

Products Affected

- OJEMDA 100MG TAB PACK (400MG ONCE WEEKLY) (16) (New Star
- OJEMDA 100MG TAB PACK (500MG ONCE WEEKLY) (20) (New Star
- OJEMDA 100MG TAB PACK (600MG ONCE WEEKLY) (24) (New Star
- OJEMDA 25MG/ML POWDER FOR ORAL SUSP (New Starts Only)

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

Products Affected

- OJJAARA 100MG TAB (New Starts Only)
- OJJAARA 150MG TAB (New Starts Only)
- OJJAARA 200MG TAB (New Starts Only)

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

Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB
- OLUMIANT 4MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Rinvoq, d) Xeljanz or e) Tyenne. For alopecia areata (initial requests): Hair loss impacts 50% or greater of the scalp. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis: Prescribed by or in consultation with, a rheumatology specialist. For alopecia areata: Prescribed by or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

- OPIPZA 10MG ORAL FILM (New Starts Only)
- OPIPZA 2MG ORAL FILM (New Starts Only)
- OPIPZA 5MG ORAL FILM (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: A) Member is unable to swallow aripiprazole tablet and B) Member is unable to use aripiprazole oral solution.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– OPSUMIT 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima or Simlandi, c) Rinvoq, d) Xeljanz, or e) Tyenne. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Xeljanz, d) Rinvoq, or e) Tyenne. For adult psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Stelara or Steqeyma, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq or i) Xeljanz. For pediatric psoriatic arthritis (initial requests): Trial of Enbrel was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, pJIA or psoriatic arthritis (adult and pediatric): Prescribed by, or in consultation with a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ORGOVYX 120MG TAB (New Starts Only)

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

Products Affected

- ORKAMBI 125-100MG ORAL GRANULES
- ORKAMBI 125-100MG TAB
- ORKAMBI 125-200MG TAB
- ORKAMBI 188-150MG ORAL GRANULES
- ORKAMBI 94-75MG ORAL GRANULES

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

Products Affected

- ORSERDU 345MG TAB (New Starts Only)
- ORSERDU 86MG TAB (New Starts Only)

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

Products Affected

- OTEZLA 10/20/30MG TAB 28-DAY STARTER PACK (55)
- OTEZLA 10/20MG TAB 28-DAY STARTER PACK (55)
- OTEZLA 20MG TAB
- OTEZLA 30MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (all requests): Trial of other agents not required. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist (dermatologist not required for mild plaque psoriasis).
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For oral ulcers associated with Behcet's disease (initial requests): Diagnosis confirmed by the presence of oral ulcers and at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test. For psoriatic arthritis and plaque psoriasis (all requests): Will not be used in combination with biologic therapy for the prescribed indication.

Products Affected

- OZEMPIC 2MG/3ML PEN INJ
- OZEMPIC 4MG/3ML PEN INJ
- OZEMPIC 8MG/3ML PEN INJ

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

Products Affected

– PANRETIN 0.1% TOPICAL GEL (New Starts Only)

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

Products Affected

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

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

Products Affected

- PIQRAY TAB 200MG DAILY DOSE PACK (28) (New Starts Only)
- PIQRAY TAB 250MG DAILY DOSE PACK (56) (New Starts Only)
- PIQRAY TAB 300MG DAILY DOSE PACK (56) (New Starts Only)

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

Products Affected

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

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

Products Affected

- PREVYMIS 120MG ORAL PELLET
- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevymis within 30 days after an allogeneic hematopoietic stem cell transplant or 7 days after kidney transplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 8 months for hematopoietic stem cell transplant or 8 months for kidney transplant.
Other Criteria	

Products Affected

- *eltrombopag 12.5mg powder for oral susp*
- *eltrombopag 25mg powder for oral susp*
- *eltrombopag 50mg tab*
- *eltrombopag 12.5mg tab*
- *eltrombopag 25mg tab*
- *eltrombopag 75mg tab*

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

Products Affected

- *modafinil 100mg tab*
- *modafinil 200mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *mercaptopurine 20mg/ml susp (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of mercaptopurine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– QINLOCK 50MG TAB (New Starts Only)

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

Products Affected

– *quinine sulfate 324mg cap*

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

Products Affected

– RADICAVA 105MG/5ML ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has a score of two or greater for each individual item on the Amyotrophic Lateral Sclerosis Functional Rating Scale-Revised (ALSFRS-R). For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of trazodone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE

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

Products Affected

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

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

Products Affected

- RETEVMO 120MG TAB (New Starts Only)
- RETEVMO 160MG TAB (New Starts Only)
- RETEVMO 40MG TAB (New Starts Only)
- RETEVMO 80MG TAB (New Starts Only)

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

Products Affected

– *sildenafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REVCOVI 2.4MG/1.5ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For adenosine deaminase severe combined immune deficiency (ADA-SCID)(initial requests): Diagnosis confirmed by one of the following: a) Absent or very low (less than 1 percent of normal) ADA activity in red blood cells, b) Increased levels of deoxyadenosine triphosphate in erythrocyte lysates compared to laboratory standards, c) Significantly decreased concentration of adenosine triphosphate in red blood cells, d) Absent or very low (less than 5 percent of normal) levels of s-adenosylhomocysteine hydrolase in red blood cells, e) Elevated levels of 2-deoxyadensoine in plasma, urine, or dried blood spots, or f) Presence of biallelic pathogenic mutations in the ADA gene. For ADA-SCID (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an immunologist or provider who specializes ADA-SCID.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

- REVUFORJ 110MG TAB (New Starts Only)
- REVUFORJ 160MG TAB (New Starts Only)
- REVUFORJ 25MG TAB (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated. For agitation associated with dementia due to Alzheimer's disease: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- REZDIFFRA 100MG TAB
- REZDIFFRA 60MG TAB
- REZDIFFRA 80MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For noncirrhotic nonalcoholic steatohepatitis (initial requests): 1) Stage F2 or F3 fibrosis confirmed by one of the following: a) Liver biopsy or b) Both of the following: i) Fibrosis-4 score greater than or equal to 1.3 and ii) One of the following: Vibration-controlled transient elastography greater than or equal to 8 kPa, magnetic resonance elastography greater than or equal to 3.63 kPa, or enhanced liver fibrosis test greater than or equal to 7.7 and 2) Attestation that the medication will be used in conjunction with diet and exercise. For noncirrhotic nonalcoholic steatohepatitis (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– REZLIDHIA 150MG CAP (New Starts Only)

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

Products Affected

– REZUROCK 200MG TAB

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

Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 30MG ER TAB
- RINVOQ 1MG/ML ORAL SOLN
- RINVOQ 45MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) A medium to very high potency topical steroid, b) A topical calcineurin inhibitor or c) An oral immunosuppressant. For ulcerative colitis (initial requests): One of the following preferred systemic agents was ineffective or not tolerated: a) a TNF antagonist, b) Starjemza, Yesintek, or Steqeyma, c) Skyrizi, or d) Tremfya. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of Cimzia was ineffective or not tolerated. For Crohn's disease (initial requests): One of the following preferred systemic agents was ineffective or not tolerated: a) Hadlima or Simlandi, b) Starjemza, Yesintek, or Steqeyma, c) Skyrizi, or d) Tremfya. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For giant cell arteritis (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, pJIA, non-radiographic axial spondyloarthritis, or giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For Crohn's disease or ulcerative colitis: Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) Body surface area involvement of 10 percent or more or b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas and 2) At least two of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- ROMVIMZA 14MG CAP (New Starts Only)
- ROMVIMZA 20MG CAP (New Starts Only)
- ROMVIMZA 30MG CAP (New Starts Only)

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

Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)
- ROZLYTREK 50MG ORAL PELLET (New Starts Only)

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

Products Affected

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

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

Products Affected

- RYBELSUS 14MG TAB
- RYBELSUS 3MG TAB
- RYBELSUS 7MG TAB

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

Products Affected

– RYDAPT 25MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

– SANTYL 250UNIT/GM TOPICAL OINTMENT

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

Products Affected

- SCEMBLIX 100MG TAB (New Starts Only)
- SCEMBLIX 20MG TAB (New Starts Only)
- SCEMBLIX 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For T315I mutation: failure of or intolerance to Iclusig required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) oral asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

- SIMLANDI 20MG/0.2ML SYRINGE
- SIMLANDI 40MG/0.4ML SYRINGE
- SIMLANDI 80MG/0.8ML SYRINGE
- SIMLANDI 40MG/0.4ML AUTO-INJECTOR
- SIMLANDI 80MG/0.8ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin. For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts and b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid and b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist or ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- SIRTURO 100MG TAB
- SIRTURO 20MG TAB

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

Products Affected

- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 150MG/ML SYRINGE
- SKYRIZI 180MG/1.2ML CARTRIDGE
- SKYRIZI 360MG/2.4ML CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin. For psoriatic arthritis (all requests): Trial of other agents not required. For Crohn's disease (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *diclofenac sodium 3% topical gel*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of tamoxifen.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

- *dasatinib 100mg tab (New Starts Only)*
- *dasatinib 140mg tab (New Starts Only)*
- *dasatinib 20mg tab (New Starts Only)*
- *dasatinib 50mg tab (New Starts Only)*
- *dasatinib 70mg tab (New Starts Only)*
- *dasatinib 80mg tab (New Starts Only)*

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– STEQEYMA 90MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

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

Products Affected

- SUNOSI 150MG TAB
- SUNOSI 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following was ineffective or not tolerated: a) modafinil or b) armodafinil.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	A nocturnal polysomnogram was used to confirm diagnosis.

Products Affected

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

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

Products Affected

- SYMDEKO TAB 4-WEEK PACK (56)
- SYMDEKO TAB 50-75MG/75MG PACK (56)

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

Products Affected

- SYMPAZAN 10MG ORAL FILM (New Starts Only)
- SYMPAZAN 20MG ORAL FILM (New Starts Only)
- SYMPAZAN 5MG ORAL FILM (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: a) Member is unable to swallow solid dosage forms of clobazam and b) Member is unable to use clobazam oral suspension.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *trientine 250mg cap*

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

Products Affected

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

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

Products Affected

- TAFINLAR 10MG TAB FOR ORAL SUSP (New Starts Only)
- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

- TALZENNA 0.1MG CAP (New Starts Only)
- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.35MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

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

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

Products Affected

- *nilotinib 150mg cap (New Starts Only)*
- *nilotinib 200mg cap (New Starts Only)*
- *nilotinib 50mg cap (New Starts Only)*

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

Products Affected

– *tazarotene 0.1% topical cream*

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

Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

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

Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

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

Products Affected

– *testosterone 1.62% (20.25mg/act) topical gel pump*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) Trial and failure or intolerance to formulary testosterone 1%. B) For initial requests: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. C) For continuation requests: Prescriber attests to improvement in the member's condition with use of the medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *testosterone 1% (12.5mg/act) topical gel pump*
- *testosterone 1% (25mg) topical gel packet*
- *testosterone 1% (50mg) topical gel packet*
- *testosterone 30mg/act topical soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests (all diagnoses): A) Attestation that hypogonadism is not age-related and B) Documentation is provided of two morning fasting testosterone levels (from two separate days) that fall below the normal range for a healthy adult male. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

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

Products Affected

– *tobramycin 300mg/5ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- *tolvaptan 15mg tab*
- *tolvaptan 15mg/30mg tab pack (56)*
- *tolvaptan 30mg tab*
- *tolvaptan 30mg/90mg tab pack (56)*
- *tolvaptan 15mg tab therapy pack (56)*
- *tolvaptan 15mg/45mg tab pack (56)*
- *tolvaptan 30mg/60mg tab pack (56)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has an eGFR of 25 ml/min/1.73m2 or greater (does not apply to generic Samsca equivalent).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist (does not apply to generic Samsca equivalent).
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *bosentan 125mg tab*
- *bosentan 62.5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TREMFYA 100MG/ML AUTO-INJECTOR
- TREMFYA 100MG/ML SYRINGE
- TREMFYA 200MG/2ML AUTO-INJECTOR
- TREMFYA 200MG/2ML AUTO-INJECTOR INDUCTION PACK FOR C
- TREMFYA 200MG/2ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin. For psoriatic arthritis (all requests): Trial of other agents not required. For Crohn's disease (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- TRIKAFTA 100-50-75MG/150MG TAB PACK (84)
- TRIKAFTA 50-37.5-25MG/75MG TAB PACK (84)
- TRIKAFTA 100-50-75MG/75MG ORAL GRANULES PACK (56)
- TRIKAFTA 80-40-60MG/59.5MG ORAL GRANULES PACK (56)

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

Products Affected

- TRULICITY 0.75MG/0.5ML AUTO-INJECTOR
- TRULICITY 1.5MG/0.5ML AUTO-INJECTOR
- TRULICITY 3MG/0.5ML AUTO-INJECTOR
- TRULICITY 4.5MG/0.5ML AUTO-INJECTOR

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

Products Affected

- TRUQAP 160MG TAB (New Starts Only)
- TRUQAP 200MG TAB (New Starts Only)

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

Products Affected

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

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

Products Affected

– TURALIO 125MG CAP (New Starts Only)

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

Products Affected

- TYENNE 162MG/0.9ML AUTO-INJECTOR
- TYENNE 162MG/0.9ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): Both of the following: a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan and ii) pulmonary function tests and b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, pJIA, systemic juvenile idiopathic arthritis, or giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist or rheumatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

- TYVASO 16MCG INH POWDER
- TYVASO 32MCG INH POWDER
- TYVASO 48MCG INH POWDER
- TYVASO 64MCG INH POWDER
- TYVASO INH POWDER 16-32-48MCG TITRATION PACK (252)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension associated with interstitial lung disease: Interstitial lung disease confirmed by high-resolution computed tomography (HRCT).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- UBRELVY 100MG TAB
- UBRELVY 50MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For acute treatment of migraine: Trial of one triptan was ineffective or not tolerated. Trial of triptan not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– *budesonide 9mg er tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of mesalamine was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– VALCHLOR 0.016% TOPICAL GEL (New Starts Only)

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

Products Affected

- VANFLYTA 17.7MG TAB (New Starts Only)
- VANFLYTA 26.5MG TAB (New Starts Only)

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

Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 1GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)
- VENCLEXTA TAB STARTER PACK (42) (New Starts Only)

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

Products Affected

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

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

Products Affected

– VERSACLOZ 50MG/ML ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: a) Member is unable to swallow clozapine tablet and b) Member is unable to use clozapine ODT.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

– *liraglutide 18mg/3ml pen inj*

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

Products Affected

– VIGAFYDE 100MG/ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following: a) Member is unable to swallow vigabatrin tablet and b) Member is unable to use vigabatrin powder for oral solution.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- *vilazodone 10mg tab (New Starts Only)*
- *vilazodone 20mg tab (New Starts Only)*
- *vilazodone 40mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, or j) duloxetine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

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

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

Products Affected

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

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

Products Affected

– VONJO 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) Jakafi, b) Inrebic, or c) Ojjaara.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VORANIGO 10MG TAB (New Starts Only)
- VORANIGO 40MG TAB (New Starts Only)

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

– VOSEVI 400-100-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) Previous hepatitis C treatments are provided.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on previous treatment experience as defined by current AASLD guidelines.

Products Affected

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

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

Products Affected

– VOWST 30000000UNIT CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	For all requests: Will not be used in combination with fecal microbiota, live for rectal use (Rebyota) or bezlotoxumab (Zinplava).

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- VYNDAMAX 61MG CAP
- VYNDAQEL 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For cardiomyopathy of transthyretin-mediated amyloidosis (initial requests): Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive Congo Red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining or B) Non-invasive testing demonstrating all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65, ii) Absence of monoclonal protein via serum protein immunofixation, iii) Absence of monoclonal protein via urine protein immunofixation and iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For cardiomyopathy of transthyretin-mediated amyloidosis (all requests): Will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra) or acoramidis (Attruby).

Products Affected

– WELIREG 40MG TAB (New Starts Only)

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

Products Affected

- WINREVAIR 45MG INJ
- WINREVAIR 60MG INJ
- WINREVAIR 45MG INJ (2 VIAL PACK)
- WINREVAIR 60MG INJ (2 VIAL PACK)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- WYOST 120MG/1.7ML INJ

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

Products Affected

- XALKORI 150MG ORAL PELLET (New Starts Only)
- XALKORI 20MG ORAL PELLET (New Starts Only)
- XALKORI 50MG ORAL PELLET (New Starts Only)
- XALKORI 200MG CAP (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)

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

Products Affected

- XCOPRI 100MG TAB (New Starts Only)
- XCOPRI 150MG TAB (New Starts Only)
- XCOPRI 200MG TAB (New Starts Only)
- XCOPRI 25MG TAB (New Starts Only)
- XCOPRI 50MG TAB (New Starts Only)
- XCOPRI TAB 100/150MG MAINTENANCE PACK (56) (New Starts On
- XCOPRI TAB 12.5/25MG TITRATION PACK (28) (New Starts Only)
- XCOPRI TAB 150/200MG PACK (56) (New Starts Only)
- XCOPRI TAB 150/200MG TITRATION PACK (28) (New Starts Only)
- XCOPRI TAB 50/100MG TITRATION PACK (28) (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XDEMVY 0.25% OPHTH SOLN

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ulcerative colitis (initial requests): Failure of, or intolerance to a TNF antagonist. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, pJIA, ankylosing spondylitis, or psoriatic arthritis: Prescribed by, or in consultation with a rheumatology specialist. For ulcerative colitis: Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– XERMELO 250MG TAB

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

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per 1 year.

Products Affected

- XOLAIR 150MG INJ
- XOLAIR 150MG/ML SYRINGE
- XOLAIR 300MG/2ML SYRINGE
- XOLAIR 75MG/0.5ML SYRINGE
- XOLAIR 150MG/ML AUTO-INJECTOR
- XOLAIR 300MG/2ML AUTO-INJECTOR
- XOLAIR 75MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma (initial requests): History within the last year of at least one asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) Treatment with systemic corticosteroids, b) Emergency department visit or c) Hospitalization. For chronic spontaneous urticaria (initial requests): Both of the following: 1) One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment and 2) Trial of Dupixent was ineffective or not tolerated. For nasal polyps (initial requests): Both of the following were ineffective or not tolerated: a) Dupixent and b) Nucala. For IgE-mediated food allergy (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic spontaneous urticaria: Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For IgE-mediated food allergy: Prescribed by, or in consultation with an allergist or immunologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Documentation of diagnosis via skin test or RAST for specific allergy sensitivity. For nasal polyps (initial requests): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For IgE-mediated food allergy (initial requests): Both of the following: a) Diagnosis supported by one of the following: i) Positive skin prick test or ii) Positive serum IgE test and b) Diagnosis confirmed by one of the following: i) Positive oral food challenge or ii) History of anaphylaxis to the suspected food allergen. For asthma (all requests): Will not be used in combination with another targeted immunomodulator

	product for the prescribed indication. For IgE-mediated food allergy (all requests): Will not be used in combination with peanut allergen powder (Palforzia).

Products Affected

– XOSPATA 40MG TAB (New Starts Only)

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

Products Affected

- XPOVIO TAB 100MG ONCE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 40MG ONCE WEEKLY CARTON (4) (New Starts Only)
- XPOVIO TAB 60MG ONCE WEEKLY CARTON (4) (New Starts Only)
- XPOVIO TAB 80MG ONCE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 40MG ONCE WEEKLY CARTON (16) (New Starts Only)
- XPOVIO TAB 40MG TWICE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 60MG TWICE WEEKLY CARTON (24) (New Starts Only
- XPOVIO TAB 80MG TWICE WEEKLY CARTON (32) (New Starts Only

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

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications.
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer and metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Both of the following were ineffective or not tolerated: a) Nubeqa and b) Erleada. For non metastatic castration sensitive prostate cancer with biochemical recurrence at high risk for metastasis: Trial of other agents not required. For homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– SODIUM OXYBATE 500MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi and b) either modafinil or armodafinil. Trial of other agents not required for patients aged 7 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For excessive daytime sleepiness with narcolepsy: A nocturnal polysomnogram was used to confirm diagnosis. For cataplexy with narcolepsy: One of the following was used to confirm diagnosis: a) nocturnal polysomnogram or b) low cerebrospinal fluid orexin-A concentration.

Products Affected

– YESINTEK 90MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) or b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- YUTREPIA 106MCG POWDER INHALER
- YUTREPIA 26.5MCG POWDER INHALER
- YUTREPIA 53MCG POWDER INHALER
- YUTREPIA 79.5MCG POWDER INHALER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension associated with interstitial lung disease: Interstitial lung disease confirmed by high-resolution computed tomography (HRCT).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZAVZPRET 10MG/ACT NASAL SPRAY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For acute treatment of migraine: Trial of one triptan was ineffective or not tolerated. Trial of triptan not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZEJULA 100MG TAB (New Starts Only)
- ZEJULA 200MG TAB (New Starts Only)
- ZEJULA 300MG TAB (New Starts Only)

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

Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

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

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

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

Products Affected

– ZONISADE 100MG/5ML ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of zonisamide.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

– ZTALMY 50MG/ML ORAL SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a CDKL5 gene mutation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

Products Affected

- ZURZUVAE 20MG CAP (New Starts Only)
- ZURZUVAE 25MG CAP (New Starts Only)
- ZURZUVAE 30MG CAP (New Starts Only)

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

Products Affected

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

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

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

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