

Moda Health Rx (PDP) Medicare Part D Plan

Prior Authorization Criteria  
Last Updated 3/1/2026

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-antitrypsin 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 90MG TAB (New Starts Only)

- ALUNBRIG 30MG 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 600mg tab (New Starts Only)

- eslicarbazepine acetate 400mg 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 36MG ER TAB
- AUSTEDO 48MG ER TAB
- AUSTEDO 9MG TAB
- AUSTEDO XR 18MG TAB
- AUSTEDO XR 6MG TAB
- AUSTEDO 30MG ER TAB
- AUSTEDO 42MG ER TAB
- AUSTEDO 6MG TAB
- AUSTEDO XR 12MG TAB
- AUSTEDO XR 24MG 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 25MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 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

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

- BALVERSA 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  |                                                                  |
| Age Restrictions       |                                                                  |
| Prescriber Restriction |                                                                  |
| Coverage Duration      | Approved for duration of 1 year.                                 |
| Other Criteria         |                                                                  |

## Products Affected

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

- *rufinamide 400mg 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  | 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 400MG TAB (New Starts Only)
- BOSULIF 50MG CAP (New Starts Only)
- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 500MG 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

— 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/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 25MG 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 160MG 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

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

- CABOMETYX 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

— *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 42MG CAP (New Starts Only)

- CAPLYTA 21MG 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. 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

— 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

— CIMZIA 200MG/ML SYRINGE STARTER KIT (6)

| 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) Starjemza, Yesintek, 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) Starjemza, Yesintek, 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) Starjemza, Yesintek, 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 30-125MG CAP (New Starts Only)
- COBENFY 20-50MG 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 75MG/0.5ML SYRINGE

— COSENTYX 150MG/ML 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% OPTH 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

— *metirosine 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

— *fidaxomicin 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 persistent or 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 persistent or chronic immune thrombocytopenia continuation requests: Member has benefited with use of this medication. |
| Age Restrictions       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Prescriber Restriction | For persistent or 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 40MG DR SPRINKLE CAP (New Starts Only)

- DRIZALMA 30MG 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 5mg cap*

— *dronabinol 2.5mg 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 300MG/2ML AUTO-INJECTOR

- DUPIXENT 200MG/1.14ML SYRINGE
- 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): Both of the following were ineffective or not tolerated: a) A medium to very high potency topical steroid and b) A topical calcineurin inhibitor (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 long-acting muscarinic antagonist/long-acting beta-agonist/inhaled corticosteroid maintenance triple 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 bullous pemphigoid (BP)(initial requests): Both of the following: a) Trial of an oral corticosteroid was ineffective or not tolerated and b) One of the following was ineffective or not tolerated: i) methotexate, ii) azathioprine, or iii) mycophenolate mofetil. 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 atopic dermatitis, prurigo nodularis, or chronic spontaneous urticaria: Allergist, immunologist, or dermatologist. For asthma or COPD: Allergist, pulmonologist, or immunologist. For nasal polyps: Allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Allergist or gastroenterologist. For BP: Dermatologist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Coverage Duration      | Approved for duration of 1 year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Other Criteria         | For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis and 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 nasal endoscopy or 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 BP (initial requests): Both of the following: a) BP Disease Area Index (BPDAI) activity score greater than or equal to 24 and b) BP is not drug-induced. 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 9MG/24HR PATCH (New Starts Only)

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

| 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

— ENSACOVE 100MG CAP (New Starts Only)

— ENSACOVE 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

— 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 801mg tab*

— *pirfenidone 267mg 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

- EXXUA 18.2MG ER TAB (New Starts Only)
- EXXUA 54.5MG ER TAB (New Starts Only)

- EXXUA 36.3MG ER TAB (New Starts Only)
- EXXUA 72.6MG 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

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

— FASENRA 30MG/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 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 40MG ER CAP (New Starts Only)
- FETZIMA ER CAP TITRATION PACK (28) (New Starts Only)
- FETZIMA 20MG ER CAP (New Starts Only)
- FETZIMA 80MG ER 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) 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

- *perampanel 0.5mg/ml oral susp (New Starts Only)*
- *perampanel 12mg tab (New Starts Only)*
- *perampanel 4mg tab (New Starts Only)*
- *perampanel 8mg tab (New Starts Only)*

- *perampanel 10mg tab (New Starts Only)*
- *perampanel 2mg tab (New Starts Only)*
- *perampanel 6mg tab (New Starts Only)*

| PA Criteria            | Criteria Details                                                                                                                                                                                                                                                                                                                                                           |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                           |
| Exclusion Criteria     |                                                                                                                                                                                                                                                                                                                                                                            |
| Required Medical Info  | For partial-onset seizures: 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 40MG TAB (New Starts Only)

- GILOTRIF 30MG 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 5MG/1.5ML PEN INJ
- OMNITROPE 5.8MG INJ
- NORDITROPIN 15MG/1.5ML PEN INJ
- OMNITROPE 10MG/1.5ML CARTRIDGE
- 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  
 — *icatibant 30mg/3ml syringe*

— HAEGARDA 3000UNIT INJ

| PA Criteria            | Criteria Details                                                                                                                                                                   |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                   |
| Exclusion Criteria     |                                                                                                                                                                                    |
| Required Medical Info  |                                                                                                                                                                                    |
| Age Restrictions       |                                                                                                                                                                                    |
| Prescriber Restriction | Prescribed by, or in consultation with, an 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 30MG TAB (New Starts Only)
- ICLUSIG 15MG 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 280MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)
- IMBRUVICA 140MG TAB (New Starts Only)
- IMBRUVICA 420MG TAB (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

— INLURIYO 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

— 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 5GM INJ
- PRIVIGEN 20GM/200ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMUNEX 1GM/10ML 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 90mg tab*

— *deferasirox 360mg 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 20MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 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

— 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 40MG TAB

— KERENDIA 20MG TAB

| PA Criteria            | Criteria Details                                                 |
|------------------------|------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria     |                                                                  |
| Required Medical Info  |                                                                  |
| 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 600MG DAILY DOSE PACK (63) (New Starts Only)
- KISQALI/FEMARA 600 CO-PACK (91) (New Starts Only)
- KISQALI TAB 400MG DAILY DOSE PACK (42) (New Starts Only)
- KISQALI/FEMARA 400 CO-PACK (70) (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 5MG SPRINKLE CAP (New Starts Only)
- KOSELUGO 25MG CAP (New Starts Only)
- KOSELUGO 7.5MG 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  |                                                                  |
| 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 14MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 20MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 4MG DAILY DOSE PACK (30) (New Starts Only)

- LENVIMA 12MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 18MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 24MG DAILY DOSE PACK (90) (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 320MG TAB (New Starts Only)
- LUMAKRAS 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

- 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 PELLETT

| 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 2MG TAB (New Starts Only)

- MEKINIST 0.5MG 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

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

| PA Criteria            | Criteria Details                                                 |
|------------------------|------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria     |                                                                  |
| Required Medical Info  |                                                                  |
| 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*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- *albuterol 5mg/ml (0.5%) inh soln*
- *amphotericin b liposomal 50mg inj*
- *aprepitant 125mg/80mg cap therapy pack (3)*
- *aprepitant 80mg cap*
- *azathioprine 50mg tab*
- *budesonide 0.5mg/2ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- *clinisol 15% inj*
- *cyclophosphamide 25mg cap*
- *cyclophosphamide 50mg cap*
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DEXTROSE 10% INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARUS XR 0.75MG TAB
- ENVARUS XR 4MG TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- HUMULIN R 500UNIT/ML INJ
- INSULIN LISPRO 100UNIT/ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- LYUMJEV 100UNIT/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 1.25mg/3ml neb soln*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- *budesonide 0.25mg/2ml inh susp*
- *budesonide 1mg/2ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- *cromolyn sodium 10mg/ml inh soln*
- CYCLOPHOSPHAMIDE 25MG TAB
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARUS XR 1MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.02% inh soln*
- JYNNEOS 0.5ML INJ
- *methylprednisolone 16mg tab*

- methylprednisolone 32mg tab
- 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

- 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

| 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 4MG CAP (New Starts Only)
- NINLARO 3MG 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 300mg cap

— droxidopa 200mg 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 SYRINGE
- NUCALA 100MG/ML AUTO-INJECTOR
- NUCALA 40MG/0.4ML SYRINGE

| PA Criteria            | Criteria Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Exclusion Criteria     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Required Medical Info  | For asthma (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 chronic obstructive pulmonary disease (COPD)(initial requests): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving long-acting muscarinic antagonist/long-acting beta-agonist/inhaled corticosteroid maintenance triple therapy. 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 or COPD: 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 nasal endoscopy or 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 COPD (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For asthma or COPD (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 250mg tab*

— *armodafinil 200mg 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)

| 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 (600MG ONCE WEEKLY) (24) (New Star
- OJEMDA 100MG TAB PACK (500MG ONCE WEEKLY) (20) (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 200MG TAB (New Starts Only)
- OJJAARA 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

— OLUMIANT 1MG TAB  
 — OLUMIANT 4MG TAB

— OLUMIANT 2MG TAB

| PA Criteria            | Criteria Details                                                                                                                                                                                                                                                                                                                                                |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                |
| Exclusion Criteria     |                                                                                                                                                                                                                                                                                                                                                                 |
| Required Medical Info  | For rheumatoid arthritis (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 5MG ORAL FILM (New Starts Only)

- OPIPZA 2MG 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 50MG/0.4ML SYRINGE
- ORENCIA 125MG/ML 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) Starjemza, Yesintek, 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 125-200MG TAB  
 — ORKAMBI 94-75MG ORAL GRANULES

— ORKAMBI 125-100MG TAB  
 — ORKAMBI 188-150MG 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 20MG TAB
- OTEZLA XR 75MG TAB
- OTEZLA 10/20MG TAB 28-DAY STARTER PACK (55)
- OTEZLA 30MG TAB
- OTEZLA/OTEZLA XR 28-DAY 10/20/30/75MG STARTER PACK (41)

| 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 with mild disease or 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 8MG/3ML PEN INJ
- OZEMPIC 4MG/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 9MG TAB (New Starts Only)
- PEMAZYRE 4.5MG 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

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

— PIQRAY TAB 300MG DAILY DOSE PACK (56) (New Starts Only)
- PIQRAY TAB 250MG 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 PELLETS  
 — PREVYMIS 480MG TAB

— PREVYMIS 240MG 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 40MG TAB (New Starts Only)
- RETEVMO 160MG 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-deoxyadenosine 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 2.5mg cap (New Starts Only)
- lenalidomide 25mg cap (New Starts Only)
- lenalidomide 15mg cap (New Starts Only)
- lenalidomide 20mg cap (New Starts Only)
- lenalidomide 5mg cap (New Starts Only)

| 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

- REVUFORJ 110MG TAB (New Starts Only)
- REVUFORJ 25MG TAB (New Starts Only)
- REVUFORJ 160MG 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 1MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 2MG 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 80MG TAB

— REZDIFFRA 60MG 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 30MG CAP (New Starts Only)
- ROMVIMZA 20MG 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 50MG ORAL PELLETT (New Starts Only)
- ROZLYTREK 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

- RUBRACA 200MG TAB (New Starts Only)

— RUBRACA 300MG TAB (New Starts Only)
- RUBRACA 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

- RYBELSUS 14MG TAB

— RYBELSUS 7MG TAB
- RYBELSUS 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 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)*

| 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 40MG TAB (New Starts Only)

- SCEMBLIX 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  | 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 7.6MG/24HR PATCH (New Starts Only)

- SECUADO 5.7MG/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 0.9MG/ML INJ

— SIGNIFOR 0.6MG/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 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 180MG/1.2ML CARTRIDGE
- SKYRIZI 150MG/ML SYRINGE
- 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 20MG INJ
- SOMAVERT 30MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 25MG 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 20mg tab (New Starts Only)
  - dasatinib 70mg tab (New Starts Only)
- dasatinib 140mg tab (New Starts Only)
  - dasatinib 50mg 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

— STARJEMZA 45MG/0.5ML INJ  
— STARJEMZA 90MG/ML SYRINGE

— STARJEMZA 45MG/0.5ML SYRINGE

| PA Criteria            | Criteria Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Uses           | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Exclusion Criteria     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Required Medical Info  | For 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 45MG/0.5ML SYRINGE

— 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

— SUBVENITE 10MG/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 lamotrigine tablet and B) Member is unable to use lamotrigine chewable dispersible tablet. |
| 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 37.5mg cap (New Starts Only)
- sunitinib 25mg 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 5MG ORAL FILM (New Starts Only)

- SYMPAZAN 20MG 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 75MG CAP (New Starts Only)

- TAFINLAR 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

— 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 0.35MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)
- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.5MG 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 25mg tab (New Starts Only)
- erlotinib 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

— 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 50mg cap (New Starts Only)

— nilotinib 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

— *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% (50mg) topical gel packet

- testosterone 1% (25mg) 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/1.73m <sup>2</sup> 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 200MG/2ML AUTO-INJECTOR
- TREMFYA 200MG/2ML SYRINGE
- TREMFYA 100MG/ML SYRINGE
- TREMFYA 200MG/2ML AUTO-INJECTOR INDUCTION PACK FOR C

| 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 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 80MCG INH POWDER
- TYVASO 32-64MCG INH POWDER MAINTENANCE PACK (224)
- TYVASO 48-64MCG INH POWDER MAINTENANCE PACK (224)
- 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 25.2GM POWDER FOR ORAL SUSP

- VELTASSA 1GM 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 50MG TAB (New Starts Only)

- VENCLEXTA 10MG 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 5MG TAB

— VERQUVO 2.5MG 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 200MG TAB (New Starts Only)
- VERZENIO 150MG 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 40mg tab (New Starts Only)

- vilazodone 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  | 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 45MG TAB (New Starts Only)
- VIZIMPRO 30MG 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

| 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 PELLETT (New Starts Only)
- XALKORI 20MG ORAL PELLETT (New Starts Only)
- XALKORI 50MG ORAL PELLETT (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 200MG TAB (New Starts Only)
- XCOPRI 50MG TAB (New Starts Only)
- XCOPRI TAB 12.5/25MG TITRATION PACK (28) (New Starts Only)
- XCOPRI TAB 150/200MG TITRATION PACK (28) (New Starts Only)
- XCOPRI 150MG TAB (New Starts Only)
- XCOPRI 25MG TAB (New Starts Only)
- XCOPRI TAB 100/150MG MAINTENANCE PACK (56) (New Starts Only)
- XCOPRI TAB 150/200MG PACK (56) (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

— XDEM VY 0.25% OPTH 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 nasal endoscopy or 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 80MG TAB (New Starts Only)

- XTANDI 40MG 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 53MCG POWDER INHALER

- YUTREPIA 26.5MCG 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 300MG TAB (New Starts Only)
- ZEJULA 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

— 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 30MG CAP (New Starts Only)
- ZURZUVAE 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 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         |                                                                  |