Products Affected

— abiraterone 250mg tab (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Urologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
</tbody>
</table>
Products Affected

- adapalene 0.1% cream
- adapalene 0.3% gel
- avita 0.025% cream
- DIFFERIN 0.1% LOTION
- tretinoin 0.01% gel
- tretinoin 0.025% gel
- tretinoin 0.05% cream
- tretinoin 0.1% cream
- adapalene 0.1% gel
- adapalene/benzoyl peroxide 0.1-2.5% gel
- avita 0.025% gel
- EPIDUO 0.3-2.5% GEL
- tretinoin 0.025% cream
- tretinoin 0.04% gel
- tretinoin 0.05% gel
- tretinoin 0.1% gel

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For rheumatoid arthritis: Intolerance to or failure of therapy with 2 of the following: Enbrel, Humira OR Rinvoq. For polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with Humira AND Enbrel. For Giant Cell Arteritis: trial and failure of corticosteroids required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Rheumatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Hematologist, Immunologist, or Genetic Specialist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- **alyq 20mg tab**
- **tadalafil 20mg tab (PAH)**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.</td>
</tr>
</tbody>
</table>
Products Affected

- AFINITOR 10MG TAB (New Starts Only)
- AFINITOR 2.5MG TAB (New Starts Only)
- AFINITOR 2MG SUSP (New Starts Only)
- AFINITOR 5MG SUSP (New Starts Only)
- AFINITOR 3MG SUSP (New Starts Only)
- AFINITOR 5MG TAB (New Starts Only)
- AFINITOR 7.5MG TAB (New Starts Only)
- everolimus 2.5mg tab (New Starts Only)
- everolimus 5mg tab (New Starts Only)
- everolimus 7.5mg tab (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist or an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— ALECENSA 150MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ALINIA 100MG/5ML SUSP
- ALINIA 500MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For diarrhea due to giardiasis, trial of metronidazole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole not required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 400MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— ARCALYST 220MG INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Rheumatology Specialist, Dermatology Specialist, or Immunologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

— ARIKAYCE 70.3MG/ML INH SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has failed to achieve negative sputum cultures after at least 6 months of multidrug regimen therapy for MAC lung disease.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, an Infectious Disease Specialist or Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- *aripiprazole 1mg/ml oral soln (New Starts Only)*
- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 15mg odt (New Starts Only)*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient is unable to swallow tablets AND Patient has tried and failed or was intolerant to risperidone ODT or solution AND olanzapine ODT or solution.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— AURYXIA 210MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 6MG TAB
- AUSTEDO 9MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For tardive dyskinesia: Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease: Patient has intolerance to or failure of therapy with tetrabenazine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist or Psychiatrist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Criteria
Last Updated  04/01/2020
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— BAXDELA 400MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 6 months subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

--- BENLYSTA 200MG/ML AUTO-INJECTOR

--- BENLYSTA 200MG/ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Member has active lupus nephritis OR severe active CNS lupus OR member is taking IV cyclophosphamide or other biologics.</td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For initial therapy: Member is required to be taking a concurrent corticosteroid unless contraindicated AND has trial and failure of one (1) of the following: hydroxychloroquine, methotrexate, azathioprine OR mycophenolate. For continuation therapy: documentation of disease improvement is required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Rheumatologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For initial therapy: Diagnosis of active systemic lupus erythematosus is defined by anti-double stranded DNA value of greater than 30 IU/mL OR low complement (C3/C4). For continuation therapy: lab values not required.</td>
</tr>
</tbody>
</table>
## Products Affected

- **BENZNIDAZOLE 100MG TAB**
- **BENZNIDAZOLE 12.5MG TAB**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 3 months subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- BRAFTOVI 75MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— BRUKINSA 80MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

— CALQUENCE 100MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Endocrinologist or Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— CARBAGLU 200MG SUSP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— CAYSTON 75MG INH SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist or Pulmonology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

--- CERDELGA 84MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, a Clinical Genetics specialist and/or a Medical Biochemical Genetics specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

EMGALITY 100MG/ML SYRINGE

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis of episodic cluster headache AND has tried and failed verapamil.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Neurologist or Headache Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.</td>
</tr>
</tbody>
</table>
Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML AUTO-INJECTOR
- EMGALITY 120MG/ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has tried and failed a 3-month or greater trial of 2 of the 3 following drug classes: anticonvulsants, vasoactive agents, antidepressants.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Neurologist or Headache Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management.</td>
</tr>
</tbody>
</table>
### Products Affected

- CHOLBAM 250MG CAP
- CHOLBAM 50MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hepatologist or Pediatric Gastroenterologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial will be 3 months, then if criteria is met approved for the rest of the plan year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Renewal requires documentation of stable or improved liver function.</td>
</tr>
</tbody>
</table>
## Products Affected

### CIMZIA 200MG INJ

### CIMZIA 200MG/ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinoq. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla. For Crohn's Disease: Intolerance to or failure of therapy with Humira. For Non-radiographic axial spondyloarthritis: Intolerance or failure of therapy with two non-steroidal anti-inflammatory drugs (NSAIDs).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Rheumatoid Arthritis, Psoriatic Arthritis, Non-radiographic axial spondyloarthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease: Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— COLCHICINE 0.6MG TAB

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>If for gout, trial of Mitigare required. If for Familial Mediterranean fever, trial of Mitigare is not required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- COMETRIQ 100MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 60MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 140MG DAILY DOSE CARTON PACK (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Cardiology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Prior Authorization Criteria

Last Updated 04/01/2020

## Products Affected

- **COSENTYX 150MG/ML AUTO-INJECTOR**
- **COSENTYX 150MG/ML SYRINGE**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methotrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— COTELLIC 20MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— CYSTARAN 0.44% OPHTH SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For the treatment of corneal cystine crystal accumulation in patients with cystinosis.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Ophthalmologist or Medical Geneticist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- *dalfampridine 10mg er tab*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **DOPTELET 20MG TAB**

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Info</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>For chronic immune thrombocytopenia: Prescribed by, or in consultation with a Hematologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>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.</td>
</tr>
</tbody>
</table>
## Products Affected

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a medium to very high potency topical steroid, a topical calcineurin inhibitor OR an oral immunosuppressant. For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: treatment with systemic corticosteroids OR emergency department visit OR hospitalization. For nasal polyps: Intolerance to, or failure of therapy of both of the following: an oral corticosteroid AND a nasal corticosteroid.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>For Atopic Dermatitis: Member must be 12 years of age or older. For Asthma: Member must be 12 years of age or older. For Nasal polyps: Member must be 18 years of age or older.</td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>Prescribed by, or in consultation with an Allergist, Immunologist, Pulmonologist, Dermatologist or ENT Specialist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) body surface area involvement of 10 percent or more OR chart documentation of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. 2) At least two (2) of the following: intractable pruritus (itching), cracking and oozing/bleeding of skin, OR impaired activities of daily living. For asthma: Member has moderate to severe asthma with an eosinophilic phenotype (documented baseline blood eosinophil concentration greater than or equal to 150 cells/mL) OR member has oral corticosteroid-dependent asthma. For nasal polyps: Bilateral nasal polyposis confirmed with sinus CT scan AND prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain).</td>
</tr>
</tbody>
</table>
**Products Affected**

- ENBREL 25MG INJ
- ENBREL 50MG/ML CARTRIDGE
- ENBREL 50MG/ML SYRINGE
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML SURECLICK INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR sорiatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methotrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— ENDARI 5000MG POWDER FOR ORAL SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— SOFOSBUVIR/VELPATASVIR 400-100MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Coverage duration of 12 weeks.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.</td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial of at least 1 anti-epileptic medication was ineffective or not tolerated.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— ERIVEDGE 150MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial of Odomzo required for locally advanced basal cell carcinoma.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ERLEADA 60MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Urologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— FARYDAK 10MG CAP (New Starts Only)
— FARYDAK 15MG CAP (New Starts Only)
— FARYDAK 20MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 12 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- FERRIPROX 100MG/ML ORAL SOLN
- FERRIPROX 1000MG TAB
- FERRIPROX 500MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Urologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— GALAFOLD 123MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation that member has an amenable glactosidase alpha gene (GLA) variant.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 16 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Medical Geneticist or a prescriber specialized in the treatment of Fabry disease.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

— GATTEX 5MG INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Dependent on parenteral support for at least 12 months and at least 3 days per week.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- BERINERT 500UNIT INJ
- HAEGARDA 2000UNT INJ
- icatibant 10mg/ml syringe
- TAKHZYRO 300MG/2ML INJ
- CINRYZE 500UNIT INJ
- HAEGARDA 3000UNT INJ
- RUCONEST 2100UNIT INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- HETLIOZ 20MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient is totally blind.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

- JUXTAPID 10MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 5MG CAP
- JUXTAPID 40MG CAP
- JUXTAPID 60MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Lipidologist, Cardiologist, or an Endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- amitriptyline 10mg tab (New Starts Only)
- amitriptyline 150mg tab (New Starts Only)
- amitriptyline 50mg tab (New Starts Only)
- AMOXAPINE 100MG TAB (New Starts Only)
- AMOXAPINE 25MG TAB (New Starts Only)
- clomipramine 25mg cap (New Starts Only)
- clomipramine 75mg cap (New Starts Only)
- desipramine 100mg tab (New Starts Only)
- desipramine 25mg tab (New Starts Only)
- desipramine 75mg tab (New Starts Only)
- doxepin 10mg/ml oral soln (New Starts Only)
- doxepin 150mg cap (New Starts Only)
- doxepin 50mg cap (New Starts Only)
- imipramine pamoate 100mg cap (New Starts Only)
- imipramine pamoate 150mg cap (New Starts Only)
- imipramine 10mg tab (New Starts Only)
- imipramine 50mg tab (New Starts Only)
- paroxetine 12.5mg er tab (New Starts Only)
- paroxetine 25mg er tab (New Starts Only)
- paroxetine 37.5mg er tab (New Starts Only)
- PAXIL 10MG/5ML SUSP (New Starts Only)
- PEXEVA 20MG TAB (New Starts Only)
- paroxetine 20mg tab (New Starts Only)
- paroxetine 30mg tab (New Starts Only)
- paroxetine 40mg tab (New Starts Only)
- PEXEVA 10MG TAB (New Starts Only)
- PEXEVA 30MG TAB (New Starts Only)
Prior Authorization Criteria
Last Updated 04/01/2020

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Requires trial and failure of one of the following: SSRI (not including paroxetine), SNRI, OR bupropion. For diagnosis of nocturnal enuresis, trial and failure of other agents not required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>PA applies to members 65 years or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>

- PEXEVA 40MG TAB (New Starts Only)
- protriptyline 5mg tab (New Starts Only)
- trimipramine 25mg cap (New Starts Only)
- protriptyline 10mg tab (New Starts Only)
- trimipramine 100mg cap (New Starts Only)
- trimipramine 50mg cap (New Starts Only)
### Products Affected

- *disopyramide 100mg cap*
- *NORPACE 100MG ER CAP*
- *disopyramide 150mg cap*
- *NORPACE 150MG ER CAP*

---

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Requires trial and failure of one of the following: beta-blocker, calcium channel blockers, OR flecainide.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>PA applies to members 65 years or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40MG/0.4ML 80MG/0.8ML
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ
- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML PEN INJECTOR
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 80MG/0.8ML INJ
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 80MG/0.8ML INJ
- HUMIRA 10MG/0.2ML SYRINGE
- HUMIRA 20MG/0.4ML SYRINGE
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). For Ulcerative Colitis or Crohn's Disease: Requires failure of, or intolerance to one of the following: corticosteroid, azathioprine, methotrexate OR 6-mercaptopurine. For Hidradenitis Suppurativa (HS): patient must have at least 3 cysts AND failure of therapy with at least one (1) oral antibiotic. For Uveitis: Requires failure of, or intolerance to therapy with a corticosteroid AND an immunosuppressant (methotrexate, mycophenolate mofetil, azathioprine, OR cyclosporine).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td><strong>PA Criteria</strong></td>
<td><strong>Criteria Details</strong></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS): Prescribed by, or in consultation with a Dermatology Specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. For Uveitis: Prescribed by, or in consultation with a Rheumatology specialist OR ophthalmologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of IDH2 mutation as detected by an FDA approved test.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist, Hemotologist, or Transplant specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **INCRELEX 40MG/4ML INJ**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **INGREZZA 40MG CAP**
- **INGREZZA 80MG CAP**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a neurologist or psychiatrist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— INREBIC 100MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hematologist or an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- paliperidone 1.5mg er tab (New Starts Only)
- paliperidone 3mg er tab (New Starts Only)
- paliperidone 6mg er tab (New Starts Only)
- paliperidone 9mg er tab (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Previous agent trials not required for schizoaffective disorder.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- ESBRIET 267MG CAP
- ESBRIET 801MG TAB
- OFEV 100MG CAP
- ESBRIET 267MG TAB
- OFEV 150MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. For systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib only): Requires intolerance to or failure of therapy with mycophenolate AND diagnosis of SSc-ILD with documentation of high-resolution computed tomography (HRCT) scan and pulmonary function tests (PFT), including forced vital capacity (FVC) and diffusing capacity for carbon monoxide (DLCO).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Will not be used in combination with other medications used to treat IPF.</td>
</tr>
</tbody>
</table>
Products Affected

— IRESSA 250MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— itraconazole 100mg cap

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For onychomycosis, must fail terbinafine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist, Pulmonary Specialist, or Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 6 months.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- FLEBOGAMMA 10% INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML IV SOLN
- PANZYGA 20GM/200ML IV SOLN
- PANZYGA 30GM/300ML IV SOLN
- PRIVIGEN 20GM/200ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 25GM/500ML INJ
- PANZYGA 10GM/100ML IV SOLN
- PANZYGA 2.5GM/25ML IV SOLN
- PANZYGA 5GM/50ML IV SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Approval will be based off BvD coverage determination.</td>
</tr>
</tbody>
</table>
### 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)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hematologist or an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has an eGFR of 25 ml/min/1.73m2 or greater.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Nephrologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- KEVZARA 150MG/1.14ML PF INJ
- KEVZARA 200MG/1.14ML PF INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinoq.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Rheumatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

— KORLYM 300MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 100MG TAB
- KUVAN 500MG POWDER FOR ORAL SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Medical Geneticist or Metabolic Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial approval of 3 months, then if criteria is met, approved for the rest of the contract year.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Cardiologist or Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— LEUKINE 250MCG INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial of or intolerance to filgrastim-sndz (Zarxio) AND tbo-filgrastim (Granix).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **lidocaine 5% patch**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Trial and failure of gabapentin of four weeks or more.</td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial and failure of gabapentin of four weeks or more.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— *lidocaine 5% ointment*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial and failure of topical lidocaine 2% gel/jelly.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— MAVYRET 100-40MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 12 years of age or older, or weigh at least 45kg.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.</td>
</tr>
</tbody>
</table>
Products Affected

— megestrol acetate 125mg/ml susp

— megestrol acetate 40mg/ml susp

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— MEKTOVI 15MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— MOVANTIK 12.5MG TAB — MOVANTIK 25MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

- ABELCET 5MG/ML INJ
- acetylcysteine 10% inh soln
- acetylcysteine 20% inh soln
- albuterol 0.21mg/ml (0.63mg/3ml) inh soln
- albuterol 0.83mg/ml (0.083%) inh soln
- AMBISOME 50MG INJ
- AMINOSYN-PF 10% SULFITE-FREE INJ
- AMINOSYN-PF 7% INJ
- AMPHOTERICIN B 50MG INJ
- aprepitant 125mg/80mg pack
- aprepitant 80mg cap
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/0.4ML SYRINGE
- ARANESP 25MCG/0.42ML SYRINGE
- ARANESP 300MCG/0.6ML SYRINGE
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 60MCG/ML INJ
- ASTAGRAF 0.5MG XL CAP
- ASTAGRAF 5MG XL CAP
- AZASAN 75MG TAB
- budesonide 0.125mg/ml inh soln
- budesonide 0.5mg/ml inh soln
- calcitriol 0.0005mg cap
- acyclovir 50mg/ml inj
- albuterol 0.417mg/ml (1.25mg/3ml) inh soln
- albuterol 1mg/ml (0.5%) inh soln
- AMINOSYN II 10% INJ
- AMINOSYN-PF 7% INJ
- aprepitant 125mg cap
- aprepitant 40mg cap
- ARANESP 10MCG/0.4ML SYRINGE
- ARANESP 100MCG/0.5ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 300MCG/ML INJ
- ARANESP 40MCG/ML INJ
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/0.3ML SYRINGE
- ASTAGRAF 1MG XL CAP
- AZASAN 100MG TAB
- azathioprine 50mg tab
- budesonide 0.25mg/ml inh soln
- calcitriol 0.00025mg cap
- calcitriol 0.001mg/ml oral soln
— cinacalcet 30mg tab
— cinacalcet 90mg tab
— CLINIMIX E 4.25/10 INJ
— CLINIMIX E 5/15 INJ
— CLINIMIX 4.25/10 INJ
— CLINIMIX 5/15 INJ
— clinisol 15% inj
— CYCLOPHOSPHAMIDE 25MG CAP
— cyclosporine modified 100mg cap
— cyclosporine modified 25mg cap
— cyclosporine 100mg cap
— DIPHTHERIA/TETANUS TOXOID INJ
— doxercalciferol 0.001mg cap
— duramorph 0.5mg/ml inj
— ENGERIX-B 10MCG/0.5ML SYRINGE
— ENVARSUS 0.75MG ER TAB
— ENVARSUS 4MG ER TAB
— FREAMINE 6.9% INJ
— gengraf 100mg/ml oral soln
— glucose 10% inj
— GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0769 MEQ/ML INJ
— heparin sodium porcine 1000unit/ml inj
— heparin sodium porcine 20000unit/ml inj
— HEPATAMINE 8% INJ
— — cinacalcet 60mg tab
— — CLINIMIX E 2.75/5 INJ
— — CLINIMIX E 4.25/5 INJ
— — CLINIMIX E 5/20 INJ
— — CLINIMIX 4.25/5 INJ
— — CLINIMIX 5/20 INJ
— — cromolyn sodium 10mg/ml inh soln
— — CYCLOPHOSPHAMIDE 50MG CAP
— — cyclosporine modified 100mg/ml oral soln
— — CYCLOSPORINE MODIFIED 50MG CAP
— — cyclosporine 25mg cap
— — doxercalciferol 0.0005mg cap
— — doxercalciferol 0.0025mg cap
— — duramorph 1mg/ml inj
— — ENGERIX-B 20MCG/ML SYRINGE
— — ENVARSUS 1MG ER TAB
— — FIASP 100UNIT/ML INJ
— — gengraf 100mg cap
— — gengraf 25mg cap
— — GLUCOSE 100MG/ML/SODIUM CHLORIDE 0.0342 MEQ/ML INJ
— — granisetron 1mg tab
— — heparin sodium porcine 10000unit/ml inj
— — heparin sodium porcine 5000unit/ml inj
— — HUMULIN R 500UNIT/ML INJ
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength/Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMOVAX 2.5UNIT/ML INJ</td>
<td>intralipid 200mg/ml inj</td>
</tr>
<tr>
<td>ipratropium bromide 0.02% inh soln</td>
<td>ipratropium/albuterol 0.5-2.5mg/3ml inh soln</td>
</tr>
<tr>
<td>levalbuterol 0.31mg inh soln</td>
<td>levalbuterol 0.63mg inh soln</td>
</tr>
<tr>
<td>levalbuterol 1.25mg inh soln</td>
<td>levalbuterol 2.5mg inh soln</td>
</tr>
<tr>
<td>levocarnitine 100mg/ml oral soln</td>
<td>levocarnitine 330mg tab</td>
</tr>
<tr>
<td>MEDROL 2MG TAB</td>
<td>methylprednisolone 16mg tab</td>
</tr>
<tr>
<td>methylprednisolone 32mg tab</td>
<td>methylprednisolone 4mg tab</td>
</tr>
<tr>
<td>methylprednisolone 8mg tab</td>
<td>mycophenolate mofetil 200mg/ml susp</td>
</tr>
<tr>
<td>mycophenolate mofetil 250mg cap</td>
<td>mycophenolate mofetil 500mg tab</td>
</tr>
<tr>
<td>mycophenolic acid 180mg dr tab</td>
<td>mycophenolic acid 360mg dr tab</td>
</tr>
<tr>
<td>NEBUPENT 300MG INH SOLN</td>
<td>Nephramine 5.4% INJ</td>
</tr>
<tr>
<td>NOVOLOG 100UNIT/ML INJ</td>
<td>nutrilipid 20% iv soln</td>
</tr>
<tr>
<td>ondansetron 0.8mg/ml oral soln</td>
<td>ondansetron 24mg tab</td>
</tr>
<tr>
<td>ondansetron 4mg odt</td>
<td>ondansetron 4mg tab</td>
</tr>
<tr>
<td>ondansetron 8mg odt</td>
<td>ondansetron 8mg tab</td>
</tr>
<tr>
<td>paricalcitol 0.001mg cap</td>
<td>paricalcitol 0.002mg cap</td>
</tr>
<tr>
<td>paricalcitol 0.004mg cap</td>
<td>pentamidine isethionate 50mg/ml inh soln</td>
</tr>
<tr>
<td>plenamine 15% inj</td>
<td>prednisolone 1mg/ml oral soln</td>
</tr>
<tr>
<td>prednisolone 10mg odt</td>
<td>prednisolone 15mg odt</td>
</tr>
<tr>
<td>PREDNISOLONE 3MG/ML ORAL SOLN</td>
<td>prednisolone 30mg odt</td>
</tr>
<tr>
<td>prednisone 1mg tab</td>
<td>PREDNISONE 1MG/ML ORAL SOLN</td>
</tr>
<tr>
<td>prednisone 10mg tab</td>
<td>prednisone 20mg tab</td>
</tr>
<tr>
<td>prednisone 2.5mg tab</td>
<td>prednisone 5mg tab</td>
</tr>
<tr>
<td>PREDNISONE 5MG/ML ORAL SOLN</td>
<td>PREDNISONE 50MG TAB</td>
</tr>
</tbody>
</table>
--- PREMASOL 10% INJ
--- PROGRAF 0.2MG GRANULES PACKET
--- PROSOL 20% INJ
--- RABAVERT 2.5UNIT/ML INJ
--- RECOMBIVAX 10MCG/ML SYRINGE
--- RECOMBIVAX 5MCG/0.5ML SYRINGE
--- RETACRIT 2000UNIT/ML INJ
--- RETACRIT 4000UNIT/ML INJ
--- SANDIMMUNE 100MG/ML ORAL SOLN
  --- sirolimus 1mg tab
  --- sirolimus 2mg tab
  --- tacrolimus 1mg cap
--- TENIVAC SYRINGE
--- TPN ELECTROLYTES INJ
--- TROPHAMINE 10% INJ
--- ZORTRESS 0.25MG TAB
--- ZORTRESS 0.75MG TAB
--- PROCALAMINE 3% INJ
--- PROGRAF 1MG GRANULES PACKET
--- PULMOZYME 1MG/ML INH SOLN
--- RECOMBIVAX HB 10MCG/ML INJ
--- RECOMBIVAX 40MCG/ML INJ
--- RETACRIT 10000UNIT/ML INJ
--- RETACRIT 3000UNIT/ML INJ
--- RETACRIT 40000UNIT/ML INJ
  --- sirolimus 0.5mg tab
  --- sirolimus 1mg/ml oral soln
  --- tacrolimus 0.5mg cap
  --- tacrolimus 5mg cap
--- TETANUS/DIPHTHERIA TOXOID INJ
--- TRAVASOL 10% INJ
--- VARUBI 90MG TAB
--- ZORTRESS 0.5MG TAB
--- ZORTRESS 1MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>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.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>N/A</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>N/A</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- NERLYNX 40MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

-- NEXAVAR 200MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- NORTHERA 100MG CAP
- NORTHERA 200MG CAP
- NORTHERA 300MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- NUBEQA 300MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Urologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For Asthma diagnosis: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Allergy Specialist, Immunologist, Pulmonary Specialist or Rheumatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— NUDEXTA 20-10MG CAP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Member has tried and failed an SSRI.</td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

### PA Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- NUZYRA 150MG TAB
- NUZYRA 150MG (14) TAB 7-DAY ORAL PACK
- NUZYRA 150MG (16) TAB 7-DAY ORAL PACK

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 1 month subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

<table>
<thead>
<tr>
<th>Products Affected</th>
<th>Products Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>— OCALIVA 10MG TAB</td>
<td>— OCALIVA 5MG TAB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Hepatologist or Gastroenterologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol.</td>
</tr>
</tbody>
</table>
## Products Affected

— ODOMZO 200MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **OLUMIANT 1MG TAB**
- **OLUMIANT 2MG TAB**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinoq.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Rheumatology specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- **OPSUMIT 10MG TAB**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Cardiologist or Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- FENTANYL 0.1MG BUCCAL TAB
- Fentanyl 0.2mg lozenge
- Fentanyl 0.4mg lozenge
- Fentanyl 0.6mg lozenge
- Fentanyl 0.8mg lozenge
- Fentanyl 1.2mg lozenge
- Fentanyl 1.6mg lozenge
- FENTORA 100MCG BUCCAL TAB
- FENTORA 200MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Breakthrough cancer pain and opioid tolerance. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For rheumatoid arthritis: Intolerance to or failure of therapy with 2 of the following: Enbrel, Humira OR Rinvoq. For polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with Humira AND Enbrel. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla.</td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Prescribed by, or in consultation with a Rheumatology Specialist.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ORFADIN 10MG CAP
- ORFADIN 20MG CAP
- ORFADIN 4MG/ML SUSP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- **ORILISSA 150MG TAB**
- **ORILISSA 200MG TAB**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has failure to, or intolerance to a non-steroidal anti-inflammatory drug (NSAID) AND a hormonal contraceptive.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an obstetrician/gynecologist or women's health/reproductive specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Member does not have known osteoporosis.</td>
</tr>
</tbody>
</table>
## Products Affected

- ORKAMBI 100-125MG GRANULES PACKET
- ORKAMBI 188-150MG GRANULES PACKET
- ORKAMBI 100-125MG TAB
- ORKAMBI 200-125MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Info</strong></td>
<td>1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>Prescribed by, or in consultation with a Pulmonologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial and continuation approval of 6 months to assess required medical info.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- OSPHENA 60MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Intolerance to or failure of therapy with generic estradiol vaginal cream and PREMARIN VAGINAL CREAM.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- OTEZLA 28-DAY STARTER PACK
- OTEZLA 30MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Info</strong></td>
<td>For oral ulcers associated with Behcet's disease: Trial of topical triamcinolone 0.1% oral paste was ineffective, not tolerated, or contraindicated. For Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). For Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>For oral ulcers associated with Behcet's disease: Prescribed by, or in consultation with, a rheumatology specialist. For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>For oral ulcers associated with Behcet's disease: 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.</td>
</tr>
</tbody>
</table>
## Products Affected

— OXERVATE 0.002% OPHTH SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Eye to be treated has never been treated with Oxervate in the past.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by an Ophthalmologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 3 months subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE
- PALYNZIQ 2.5MG/0.5ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member is 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Medical Geneticist or Metabolic Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- REPATHA 120MG/ML CARTRIDGE
- REPATHA 140MG/ML SYRINGE
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) Current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) member had 10% or greater reduction in LDL-C on PCSK9 inhibitor therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) includes documentation of the diagnosis, which may include, but is not limited to the following conditions: Familial hyperchylomicronemia or Buerger-Gruetz Syndrome, Familial Combined Hyperlipidemia, Familial dysbetalipoproteinemia, Familial Triglyceridemia, Endogenous Hypertriglyceridemia.</td>
</tr>
</tbody>
</table>
Products Affected

— PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
— PIQRAY 250MG DAILY DOSE PACK (New Starts Only)
— PIQRAY 300MG DAILY DOSE 150MG PACK (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of HR +/-HER2- and PIK3CA-mutation: Used in combination with fulvestrant: Used following progression on or after an endocrine-based therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by Hematologist or Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

- LOKEELMA 10GM PACKET
- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP
- LOKEELMA 5GM PACKET
- VELTASSA 25.2GM POWDER FOR ORAL SUSP

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has baseline persistent potassium level greater than 5.0 mmol/L.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Nephrologist, Cardiologist, or Endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- CRINONE 4% VAGINAL GEL
- CRINONE 8% VAGINAL GEL

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— PROLIA 60MG/ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For osteoporosis: Trial of an oral bisphosphonate was not tolerated.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- PROMACTA 12.5MG POWDER FOR ORAL SUSP
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB
- PROMACTA 12.5MG TAB
- PROMACTA 50MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— QBRELIS 1MG/ML ORAL SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Approval requires attestation of patient's inability to swallow solid dosage forms of lisinopril.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— RAVICTI 1.1GM/ML ORAL SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Requires trial of sodium phenylbutyrate powder.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Metabolic Physician or Medical Geneticist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 12MG/0.6ML SYRINGE
- RELISTOR 8MG/0.4ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient, member must have tried and failed lactulose.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 4 months, subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- sildenafil 20mg tab

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. For Major Depressive Disorder, patient has tried and failed or was intolerant to aripiprazole.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— RINVOQ 15MG ER TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Rheumatoid Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of ROS1 rearrangement or NTRK gene fusion mutation required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with, an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- RUZURGI 10MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed with one of the following: Presence of voltage-gated calcium channel antibodies OR electrophysiologic compound muscle action potential test findings are consistent with LEMS.</td>
</tr>
</tbody>
</table>
## Products Affected

— RYDAPT 25MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- vigabatrin 50mg/ml oral soln (New Starts Only)
- vigabatrin 500mg tab (New Starts Only)
- vigadrone 500mg oral soln (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- SAPHRIS 10MG SL TAB (New Starts Only)
- SAPHRIS 2.5MG SL TAB (New Starts Only)
- SAPHRIS 5MG SL TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- SIMPONI 100MG/ML AUTO-INJECTOR
- SIMPONI 100MG/ML INJ
- SIMPONI 50MG/0.5ML AUTO-INJECTOR
- SIMPONI 50MG/0.5ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Rinvoq. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of therapy with Humira.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— SIRTURO 100MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 6 months subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— SKYRIZI SYRINGE 150MG DOSE PACK

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— *diclofenac sodium 3% gel*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Endocrinologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

- SPRITAM 1000MG ODT (New Starts Only)
- SPRITAM 250MG ODT (New Starts Only)
- SPRITAM 500MG ODT (New Starts Only)
- SPRITAM 750MG ODT (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member must have a trial or contraindication to generic levetiracetam.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla. For Crohn's Disease and Ulcerative colitis: Intolerance to or failure of therapy with Humira.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>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 Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

— STIVARGA 40MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- SUTENT 12.5MG CAP (New Starts Only)
- SUTENT 25MG CAP (New Starts Only)
- SUTENT 37.5MG CAP (New Starts Only)
- SUTENT 50MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- SYLATRON 200MCG INJ (New Starts Only)
- SYLATRON 300MCG INJ (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Pulmonologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— SYMPROIC 0.2MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Prior Authorization Criteria

Last Updated 04/01/2020

## Products Affected

- *trientine 250mg tab*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- **bexarotene 75mg cap (New Starts Only)**
- **TARGRETIN 1% GEL (New Starts Only)**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 200MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- TAVALISSE 100MG TAB
- TAVALISSE 150MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with a Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— TEGSEDI 189MG/ML SYRINGE

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by a Neurologist, Cardiologist, Hematologist, or other specialist experienced in the diagnosis and treatment of hereditary transthyretin-mediated amyloidosis.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Hereditary transthyretin-mediated amyloidosis confirmed by genetic sequencing AND amyloidosis confirmed by positive tissue biopsy or laser capture tandem mass spectrometry.</td>
</tr>
</tbody>
</table>
## Products Affected

- **tetrabenazine 12.5mg tab**
- **tetrabenazine 25mg tab**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has chorea due to Huntington's Disease.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- THALOMID 100MG CAP (New Starts Only)
- THALOMID 200MG CAP (New Starts Only)
- THALOMID 50MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Infectious Disease Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- TIBSOVO 250MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **TOBI PODHALER KIT 28MG PACK**
- **tobramycin 60mg/ml inh soln**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Approval will be based off BvD coverage determination.</td>
</tr>
</tbody>
</table>
Products Affected

- AMCINONIDE 0.1% CREAM
- beser 0.05% lotion
- clobetasol propionate 0.05% e foam
- clobetasol propionate 0.05% lotion
- clobetasol propionate 0.05% spray
- desonide 0.05% cream
- fluticasone propionate 0.05% lotion

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Requires trial of two formulary topical steroids.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- MULPLETA 3MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 1 month subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **bosentan 125mg tab**
- **bosentan 62.5mg tab**
- **TRACLEER 32MG TAB FOR ORAL SUSP**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- QUDEXY 100MG XR CAP (New Starts Only)
- QUDEXY 200MG XR CAP (New Starts Only)
- QUDEXY 50MG XR CAP (New Starts Only)
- TOPIRAMATE 150MG ER CAP (New Starts Only)
- TOPIRAMATE 25MG ER CAP (New Starts Only)
- TROKENDI 100MG XR CAP (New Starts Only)
- TROKENDI 25MG XR CAP (New Starts Only)
- QUDEXY 150MG XR CAP (New Starts Only)
- QUDEXY 25MG XR CAP (New Starts Only)
- TOPIRAMATE 100MG ER CAP (New Starts Only)
- TOPIRAMATE 200MG ER CAP (New Starts Only)
- TOPIRAMATE 50MG ER CAP (New Starts Only)
- TROKENDI 200MG XR CAP (New Starts Only)
- TROKENDI 50MG XR CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome OR is using for prophylaxis of migraine headache.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— TURALIO 200MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- TYKERB 250MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has received prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- budesonide 9mg er tab
- UCERIS 2MG/ACT FOAM

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

- UPTRAVI TITRATION PACK
- UPTRAVI 1200MCG TAB
- UPTRAVI 1600MCG TAB
- UPTRAVI 400MCG TAB
- UPTRAVI 800MCG TAB
- UPTRAVI 200MCG TAB
- UPTRAVI 1000MCG TAB
- UPTRAVI 1400MCG TAB
- UPTRAVI 600MCG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— VALCHLOR 0.016% GEL (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has received prior skin-directed therapy such as topical steroids.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— VENCLEXTA 10MG TAB (New Starts Only) — VENCLEXTA 100MG TAB (New Starts Only)
— VENCLEXTA 10/100/50MG STARTING PACK (New Starts Only) — VENCLEXTA 50MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **VENTAVIS 10MCG/ML INH SOLN**
- **VENTAVIS 20MCG/ML INH SOLN**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Diagnosis confirmed by right heart catheterization.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Pulmonologist or Cardiologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of NTRK gene fusion mutation required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Infectious Disease Physician or Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for 6 months subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- VOSEVI 400-100-100MG TAB

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Member must be 18 years of age or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Coverage duration of 12 weeks.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.</td>
</tr>
</tbody>
</table>
Products Affected

— VOTRIENT 200MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— XATMEP 2.5MG/ML ORAL SOLN

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For polyarticular juvenile idiopathic arthritis: patient must have trial of or inability to use oral methotrexate tablet. For acute lymphoblastic leukemia: trial of oral methotrexate tablet is not required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **XELJANZ 10MG TAB**
- **XELJANZ 5MG TAB**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Info</strong></td>
<td>For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, or Rinvoq. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of therapy with Humira.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>For Rheumatoid Arthritis or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Criteria

_Last Updated 04/01/2020_
Products Affected

- XGEVA 120MG/1.7ML INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- **XIFAXAN 550MG TAB**

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.</td>
</tr>
</tbody>
</table>
### Products Affected

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

<table>
<thead>
<tr>
<th><strong>PA Criteria</strong></th>
<th><strong>Criteria Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Required Medical Info</strong></td>
<td>1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's IgE level must be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) , AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contraindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.</td>
</tr>
<tr>
<td><strong>Prescriber Restriction</strong></td>
<td>Prescribed by, or in consultation with an Allergy Specialist, Pulmonary Specialist, Dermatology Specialist or Immunologist.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— XOSPATA 40MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Documentation of FLT3 mutation required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Products Affected**

- XPOVIO 100MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 60MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG ONCE WEEKLY PACK (New Starts Only)
- XPOVIO 80MG TWICE WEEKLY PACK (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Documentation of prior therapies required and include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody.</td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Prescribed by, or in consultation with an Oncologist or Hematologist.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— XTANDI 40MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>For metastatic castration-resistant prostate cancer (mCRPC), failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Urologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— XULTOPHY 100UNIT-3.6MG/ML PEN INJ

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with a maximally dosed GLP-1 receptor agonist or basal insulin greater than or equal to thirty (30) units per day, OR member is currently using basal insulin AND a GLP-1 receptor agonist.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- **XYREM 500MG/ML ORAL SOLN**

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Neurologist, Pulmonologist, or Sleep Medicine Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Prior Authorization Criteria

---

**Last Updated** 04/01/2020

## Products Affected

- *miglustat 100mg cap*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with a Medical Geneticist, Hematologist, or Metabolic Physician.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— ZEJULA 100MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

— ZELBORAF 240MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Products Affected

— ZOLINZA 100MG CAP (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist or Dermatologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
# Products Affected

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

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND idelalisib (ZYDELAG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ZYKADIA 150MG TAB (New Starts Only)

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td>Prescribed by, or in consultation with an Oncologist.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- ANDRODERM 2MG/24HR PATCH
- ANDRODERM 4MG/24HR PATCH
- TESTOSTERONE 1% GEL PUMP
- Testosterone 1% (25mg) gel
- Testosterone 1.62% gel pump
- Testosterone 1.62% (1.25gm) gel
- Testosterone 1.62% (2.5gm) gel

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Two morning testosterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
## Products Affected

- glyburide 1.25mg/metformin 250mg tab
- glyburide 2.5mg/metformin 500mg tab
- glyburide 5mg/metformin 500mg tab

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Prior Authorization applies to patients 65 years or older.</td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>If prescribed for diabetes (sulfonylurea), trial or intolerance to ONE of the following: glipizide or glimepiride.</td>
</tr>
</tbody>
</table>
# Prior Authorization Criteria

**Last Updated** 04/01/2020

## Products Affected

- DOPELET 40MG DAILY DOSE PACK
- DOPELET 60MG DAILY DOSE PACK

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### Products Affected

- *zolpidem tartrate 10mg tab*
- *zolpidem tartrate 5mg tab*

<table>
<thead>
<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Info</td>
<td>Trial or intolerance to ONE Non-High Risk formulary alternative: Trazodone or Mirtazapine.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restriction</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Approved for duration of contract year subject to formulary change and member eligibility.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>