

ACTEMRA IV (S)

Products Affected

- Actemra INJ 200MG/10ML, 400MG/20ML, 80MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orenzia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), or b) attestation demonstrating a trial may be inappropriate, OR c) For continuation of prior therapy. Systemic Juvenile Idiopathic arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orenzia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Cytokine Release Syndrome (CRS): Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [e.g., Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel)]. Coronavirus disease 2019 (COVID-19): Diagnosis of COVID-19. Patient is hospitalized. Currently receiving systemic corticosteroids. Patient requires one of the following: supplemental oxygen, non-invasive mechanical ventilation, invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).

Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA, GCA (initial): Prescribed by or in consultation with a rheumatologist. CRS: Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	RA, SJIA, PJIA, GCA (Init): 6 mo, (reauth): 12 mo. CRS: 2 mo. COVID-19: 14 days.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GCA (Reauth): Patient demonstrates positive clinical response to therapy.

ACTEMRA SC (S)

Products Affected

- Actemra INJ 162MG/0.9ML

- Actemra Actpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy.

ACTIMMUNE (S)

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ADALIMUMAB-AATY (S)

Products Affected

- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe Kit
- Adalimumab-aaty Cd/uc/hs Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.
Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

ADALIMUMAB-ADBM (S)

Products Affected

- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	---

ADCIRCA (S)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ADEMPAS (S)

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, CTEPH (Reauth): Patient demonstrates positive clinical response to therapy.

AFINITOR (S)

Products Affected

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast Cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

AFINITOR DISPERZ (S)

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older. TSC-associated partial-onset seizures: Patient is 2 years of age or older.
Prescriber Restrictions	TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

AIMOVIG (S)

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.

AKEEGA (S)

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer. Disease is all of the following: a) metastatic, b) castration-resistant, and c) deleterious or suspected deleterious BRCA-mutated (BRCAm). Used in combination with prednisone. One of the following: a) Used in combination with a gonadotropin-releasing hormone (GnRH) analog, or b) Patient has had a bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ALDURAZYME (S)

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis I: confirmed diagnosis of Hurler or Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I), OR confirmed diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I) who have moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ALECENSA (S)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ALIQOPA (S)

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ALPHA-1 PROTEINASE INHIBITOR, NON-PREFERRED (S)

Products Affected

- Aralast Np INJ 1000MG, 500MG
- Glassia INJ 1000MG/50ML
- Zemaira INJ 1000MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. One of the following: Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry) OR the patient has a concomitant diagnosis of necrotizing panniculitis. Trial and failure, or intolerance to Prolastin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

ALUNBRIG (S)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

AMPYRA (S)

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (Initial): 6 months. (Reauth): 12 months.
Other Criteria	MS (Reauth): Physician confirmation that the patient's walking improved with therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).

APOKYN (S)

Products Affected

- Apomorphine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	PD (Initial): Not used with any 5-HT ₃ antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of PD. Patient is experiencing acute intermittent hypomobility (defined as “off” episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Used in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, etc.).
Age Restrictions	N/A
Prescriber Restrictions	PD (Initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	PD (Reauth): Patient demonstrates positive clinical response to therapy.

ARANESP (S)

Products Affected

- Aranesp Albumin Free INJ
100MCG/0.5ML, 100MCG/ML,
10MCG/0.4ML, 150MCG/0.3ML,
200MCG/0.4ML, 200MCG/ML,
25MCG/0.42ML, 25MCG/ML,
300MCG/0.6ML, 40MCG/0.4ML,
40MCG/ML, 500MCG/ML,
60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. CKD (init, reauth), Chemo (init), MDS (init): Verify iron evaluation for adequate iron stores. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD (Init): 6 mo. CKD (reauth): 12 mo. Chemo(init, reauth): 3 mo. MDS: (init) 3 mo,(reauth) 12 mo.

Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
-----------------------	--

ARCALYST (S)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cryopyrin-Associated Periodic Syndromes (CAPS) (Initial): Diagnosis of CAPS, including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic. Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. Patient weighs at least 10 kg. Patient is currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L). Recurrent Pericarditis (Initial): Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart. Trial and failure, contraindication, or intolerance (TF/C/I) to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	CAPS (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or specialist with expertise in the management of CAPS. Recurrent Pericarditis (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CAPS, Recurrent Pericarditis (initial, reauth): 12 months. DIRA: 12 months.

Other Criteria	CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count. Recurrent Pericarditis (Reauth): Patient demonstrates positive clinical response to therapy.
-----------------------	---

ARIKAYCE (S)

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycobacterium avium complex (MAC) lung disease: Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	12 months
Other Criteria	N/A

ARZERRA (S)

Products Affected

- Arzerra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

AUBAGIO (S)

Products Affected

- Teriflunomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

AUGTYRO (S)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced, or b) metastatic. Patient has ROS1 rearrangement positive tumor(s). Solid Tumors: Diagnosis of solid tumors. Disease has neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1). Disease is one of the following: a) Locally advanced, b) Metastatic, or c) Unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: a) Disease has progressed following previous treatment (e.g., radiation therapy, systemic therapy, tyrosine kinase inhibitor [TKI]), or b) Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months.
Other Criteria	All indications: Approve for continuation of prior therapy.

AUSTEDO (S)

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated with Huntington's disease. Tardive dyskinesia (initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.
Age Restrictions	N/A
Prescriber Restrictions	Huntington's disease chorea (initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial: 3 months. Reauth: 12 months
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

AVASTIN (S)

Products Affected

- Avastin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Trial and failure, or intolerance to Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). Approve for continuation of prior therapy.

AYVAKIT (S)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. Disease is one of the following: unresectable or metastatic. Presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Advanced Systemic Mastocytosis (AdvSM): Diagnosis of AdvSM. Patient has one of the following: a) aggressive systemic mastocytosis (ASM), b) systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or c) mast cell leukemia (MCL). Platelet count is greater than $50 \times 10^9/L$. Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than $50 \times 10^9/L$.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BAFIERTAM (S)

Products Affected

- Bafiertam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

BALVERSA (S)

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). Disease is one of the following: Locally advanced or Metastatic. Presence of susceptible fibroblast growth factor receptor (FGFR) 3 genetic alterations as detected by an U.S. Food and Drug Administration (FDA)-approved test (therascreen FGFR RGQ RT-PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed on or after at least one line of prior systemic therapy (e.g., chemotherapy). One of the following: 1) Patient had been treated with prior PD-1 inhibitor (e.g., Opdivo [nivolumab], Keytruda [pembrolizumab]) or PD-L1 inhibitor therapy (e.g., Bavencio [avelumab]) or 2) Patient is not a candidate for PD-1 or PD-L1 inhibitor therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BAVENCIO (S)

Products Affected

- Bavencio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BELEODAQ (S)

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BENLYSTA (S)

Products Affected

- Benlysta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)]). Lupus Nephritis (init): Diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide).
Age Restrictions	SLE, Lupus Nephritis (init): Benlysta IV (vial), SC (prefilled syringe): Patient is 5 years of age or older.
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist. Lupus Nephritis (init): Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	SLE, Lupus Nephritis (init, reauth): 6 months
Other Criteria	SLE, Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.

BERINERT (S)

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

BESREMI (S)

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of polycythemia vera as confirmed by one of the following: A) All of the following: 1) One of the following: a) Hemoglobin greater than 16.5 g/dL for men or hemoglobin greater than 16.0 g/dL for women, b) Hematocrit greater than 49% for men or hematocrit greater than 48% for women, or c) Increased red cell mass, AND 2) Bone marrow biopsy showing hypercellularity for age with trilineage growth (panmyelosis) including prominent erythroid, granulocytic and megakaryocytic proliferation with pleomorphic, mature megakaryocytes, AND 3) One of the following: a) Presence of JAK2 or JAK2 exon 12 mutation or b) Subnormal serum erythropoietin level, OR B) All of the following: 1) Patient with sustained absolute erythrocytosis as demonstrated by one of the following: a) Hemoglobin greater than 18.5 g/dL for men or greater than 16.5 g/dL for women, or b) Hematocrit greater than 55.5% for men or greater than 49.5% for women, AND 2) Presence of JAK2 or JAK2 exon 12 mutation, AND 3) Subnormal serum erythropoietin level. For high-risk polycythemia vera only (patient greater than or equal to 60 years old and/or prior thrombosis history), trial and inadequate response, contraindication or intolerance to hydroxyurea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

BLINCYTO (S)

Products Affected

- Blincyto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL): Diagnosis of relapsed or refractory CD19-positive B-cell precursor acute lymphoblastic leukemia/acute lymphoblastic lymphoma. Minimal residual disease (MRD)-positive B-cell precursor ALL (MRD+ ALL): Diagnosis of CD19-positive B-cell precursor ALL. Patient is in their first or second complete remission. Documentation of MRD greater than or equal to 0.1%.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ALL: 12 months. MRD+ ALL: 6 months.
Other Criteria	Subject to Part B vs. Part D review. All Indications: Approve for continuation of prior therapy.

BORTEZOMIB (S)

Products Affected

- Bortezomib INJ 3.5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BOSULIF (S)

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous/myeloid leukemia (CML): Diagnosis of Philadelphia chromosome-positive (Ph+) CML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BOTOX (S)

Products Affected

- Botox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuromuscular Disorders (init): Diagnosis of one of the following: Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), spasticity, VII cranial nerve disorders (hemifacial spasms), cervical dystonia. Hyperhidrosis(HH): (Init) Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Migraine:(Init) Dx of chronic migraines (greater than or equal to 15 headache days per month with headache lasting 4 hours a day or longer). History of failure (after at least a two month trial), contraindication or intolerance to two of the following preventive treatments for migraine from different mechanisms of action: a) Elavil [amitriptyline] or Effexor [venlafaxine], b) Depakote/Depakote ER [divalproex sodium] or Topamax [topiramate], c) atenolol, propranolol, nadolol, timolol, or metoprolol, d) candesartan, e) Lisinopril. Achalasia:(Init) High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of either nocturnal pain and bleeding or postdefecation pain. Chronic Back Pain (CBP):(Init) Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI):(init) Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis, spinal dysraphisms such as spina bifida) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB): (init) Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.
Age Restrictions	N/A

Prescriber Restrictions	Migraine (initial): Prescribed by a neurologist, pain specialist, or headache specialist. CBP (initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.
Coverage Duration	Achalasia: 6moCBP:1 tx(series of injxs)UI:3mo Other:3mo
Other Criteria	UI, OAB, CBP, Neuromuscular Disorders:(Reauth) Patient demonstrates positive clinical response to therapy. At least 3 months have or will have elapsed since the last treatment. HH:(Reauth) At least a 2-point improvement in HDSS. Migraine:(Reauth) Patient has experienced a positive response to therapy (eg, a reduction in headache frequency or intensity, a reduction in the number of workdays missed due to migraines). Confirmation of decreased utilization of pain medications (eg, narcotic analgesics, NSAIDs) or triptans, or a reduction in the number of ER visits. Achalasia:(Reauth) Documentation of improvement or reduction in symptoms of achalasia (ie, dysphagia, regurgitation, chest pain). At least 6 months have or will have elapsed since last series of injections. AF: (Reauth) Incomplete healing of fissure or recurrence of fissure.

BRAFTOVI (S)

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib). Colorectal Cancer: One of the following diagnoses: Colon Cancer or Rectal Cancer. One of the following: 1) Unresectable or advanced disease or 2) Metastatic disease. Cancer is BRAF V600E mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following a) Used in combination with Erbitux (cetuximab) AND b) One of the following: i) Patient has received prior therapy OR ii) Used in combination with mFOLFOX6. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

BRIVIACT (S)

Products Affected

- Briviact

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Partial-onset seizures: Diagnosis of partial-onset seizures.
Age Restrictions	Patient is 1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BRONCHITOL (S)

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Patient has passed the Bronchitol Tolerance Test (BTT).
Age Restrictions	CF (initial): Patient is 18 years of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	CF (initial): 6 months. CF (reauth): 12 months.
Other Criteria	CF (reauth): Patient demonstrates positive clinical response to therapy.

BRUKINSA (S)

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Patient has received at least one prior therapy for MCL (e.g., chemotherapy). Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed or refractory. Patient has received at least one prior anti-CD20-based regimen for MZL (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of ONE of the following: CLL or SLL. Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Patient has received at least two prior lines of systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.

BYETTA BYDUREON (S)

Products Affected

- Bydureon Bcise
- Byetta
- Exenatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

CABLIVI (S)

Products Affected

- Cablivi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acquired thrombotic thrombocytopenic purpura (aTTP): Diagnosis of aTTP. First dose was/will be administered by a healthcare provider as a bolus intravenous injection. Used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids). One of the following: 1) Used in combination with plasma exchange or 2) both of the following: patient has completed plasma exchange and less than 59 days have or will have elapsed beyond the last plasma exchange.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	3 months
Other Criteria	N/A

CABOMETYX (S)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate). Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease or patient is refractory to radioactive iodine treatment or ineligible. Neuroendocrine Tumors: Diagnosis of one of the following: 1) Pancreatic neuroendocrine tumors (pNET) or 2) Extra-pancreatic neuroendocrine tumors (epNET). Disease is one of the following: 1) Unresectable, 2) Locally advanced, or 3) Metastatic. Tumors are well-differentiated. Patient has been previously treated (e.g., octreotide, lanreotide, chemotherapy).
Age Restrictions	DTC: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CALQUENCE (S)

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL). One of the following: A) All of the following: 1) Patient has received no prior therapy for MCL (e.g., bortezomib, rituximab), 2) Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) Used in combination with bendamustine and rituximab, OR B) Patient has received at least one prior therapy for MCL. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CAPLYTA (S)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: asenapine, aripiprazole, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, ziprasidone. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate. Trial and failure, contraindication, or intolerance to quetiapine (IR or ER) or olanzapine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

CAPRELSA (S)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of one of the following: a) metastatic medullary thyroid cancer (MTC) or b) unresectable locally advanced MTC. Patient has symptomatic disease or progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CAYSTON (S)

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs.
Age Restrictions	CF (Initial): 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	CF (Initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

CERDELGA (S)

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Gaucher disease type 1. Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test.
Age Restrictions	Gaucher disease: Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A

CEREZYME (S)

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	Gaucher disease: Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A

CHENODAL (S)

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of radiolucent gallstones. Patient has a well-opacifying gallbladder visualized by oral cholecystography. Trial and failure, contraindication or intolerance to ursodiol. Patient is not a candidate for surgery. Stones are not calcified (radiopaque) or radiolucent bile pigment stones.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist or provider who has specialized expertise in the management of gallstones
Coverage Duration	Initial, reauth: 12 months.
Other Criteria	Reauth: Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by oral cholecystograms or ultrasonograms.

CHOLBAM (S)

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of a peroxisomal disorder based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses: 4 months (initial), 12 months (reauth).
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement in liver function.

CHORIONIC GONADOTROPIN (S)

Products Affected

- Chorionic Gonadotropin INJ
- Novarel INJ 5000UNIT

- Pregnyl
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (MHH) (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and one of the following: a) low LH (below normal reference value provided by the physician's laboratory) or b) low FSH (below normal reference value provided by the physician's laboratory).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. MHH (initial, reauth): 12 months.
Other Criteria	Excluded if used to promote fertility. MHH (Reauth): Patient demonstrates positive clinical response to therapy.

CIALIS (S)

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use of nitrates.
Required Medical Information	Diagnosis of benign prostatic hyperplasia (BPH). Trial and failure, contraindication, or intolerance to an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CICLOPIROX (S)

Products Affected

- Ciclopirox Nail Lacquer

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All of the following: 1) Patient does not have lunula (matrix) involvement, 2) one of the following: a) Diagnosis of onychomycosis of the toenails, OR b) Diagnosis of onychomycosis of the fingernails, 3) Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, 4) If toenail onychomycosis, patient has mild to moderate disease involving at least 1 target toenail, AND 5) One of the following: a) For onychomycosis of fingernails, Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine, or b) For onychomycosis of toenails, trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	N/A

CIMZIA (S)

Products Affected

- Cimzia INJ 200MG/ML

- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA, initial): Diagnosis (dx) of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA, initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel, one formulary adalimumab product, Orencia, Rinvoq/LQ, or Xeljanz, OR b) for continuation of prior therapy. Psoriatic Arthritis (PsA, initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Either a TF/C/I to two of the following: Cosentyx SC (secukinumab), Enbrel, one formulary adalimumab product, Orencia, Otezla (apremilast), Skyrizi (risankizumab-rzaa), one formulary ustekinumab product, Rinvoq/LQ, or Xeljanz/XR, OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS, initial): Dx of active AS. TF/C/I to two of the following: Enbrel, one formulary adalimumab product, Cosentyx SC, Rinvoq, Xeljanz/XR, OR for continuation of prior therapy. Plaque Psoriasis (PsO) (initial): Dx of moderate to severe PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. TF/C/I to two of the following: one formulary adalimumab product, Enbrel, Otezla, Skyrizi (risankizumab), Sotyktu (deucravacitinib), one formulary ustekinumab product, Cosentyx, OR for continuation of prior therapy.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	CD (init): Prescribed by or in consultation with a gastroenterologist. RA, PJIA, AS, nr-axSpA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	RA, PJIA, PsA, AS, PsO, nr-axSpA (init): 6 mo, (reauth): 12 mo. CD (init): 16 wks. (reauth): 12 mo.

Other Criteria	Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.). Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen) at maximally tolerated doses. Crohn's Disease (CD, initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to two of the following: one formulary adalimumab product, Rinvoq, Skyrizi (risankizumab-rzaa), or one formulary ustekinumab product, OR for continuation of prior therapy. RA, PJI (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.
------------------------------	--

CINRYZE (S)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

COBENFY (S)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: a) aripiprazole, b) asenapine, c) olanzapine, d) paliperidone, e) quetiapine (IR or ER), f) risperidone, or g) ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

COMETRIQ (S)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	Approve for continuation of prior therapy.

COPIKTRA (S)

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease is relapsed or refractory. Trial and failure, contraindication, or intolerance to at least two prior therapies for CLL/SLL (e.g., Leukeran [chlorambucil], Gazyva [obinutuzumab], Arzerra [ofatumumab], Bendeka [bendamustine], Imbruvica [ibrutinib], Rituxan [rituximab], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

COSENTYX (S)

Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen

- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	Plaque psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy.

COTELLIC (S)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm. Used as monotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CTEXTLI (S)

Products Affected

- Ctextli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease). Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: a) Neurologist, b) Geneticist, or c) Metabolic disease specialist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

CYLTEZO (S)

Products Affected

- Cyltezo
- Cyltezo Starter Package For Crohns Disease/uc/hs

- Cyltezo Starter Package For Psoriasis
- Cyltezo Starter Package For Psoriasis/uveitis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. All Indications (Initial): Trial of two of the following: Humira, brand adalimumab-adbm, or brand adalimumab-aaty.
Age Restrictions	N/A

Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

CYRAMZA (S)

Products Affected

- Cyramza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

D.H.E. 45 (s)

Products Affected

- Dihydroergotamine Mesylate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Migraines (initial): Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans. Cluster Headaches (CH) (initial): Diagnosis of cluster headache. Trial and failure, contraindication, or intolerance to sumatriptan injection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Migraines (initial): 12 months, CH (initial): 3 months. Migraines, CH (reauth): 12 months.
Other Criteria	Migraines (reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). CH (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity.

DALIRESP (S)

Products Affected

- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD) (initial): Diagnosis of COPD. History of COPD exacerbations which required the use of systemic corticosteroids, antibiotics, or hospital admission. Trial and failure, intolerance, or contraindication to two prior therapies for COPD (e.g., Combivent, Spiriva).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD (init, reauth): 12 months
Other Criteria	COPD (reauth): Patient demonstrates positive clinical response to therapy.

DANYELZA (S)

Products Affected

- Danyelza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

DANZITEN (S)

Products Affected

- Danziten

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

DARAPRIM (S)

Products Affected

- Pyrimethamine TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Toxoplasmosis: 1) Patient is using pyrimethamine for the active treatment of toxoplasmosis (e.g., toxoplasmic encephalitis, ocular toxoplasmosis), secondary prophylaxis of toxoplasmosis, or treatment of congenital toxoplasmosis OR 2) Patient is using pyrimethamine for the primary prophylaxis of toxoplasmosis, patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX), and one of the following: patient has been re-challenged with TMP-SMX using a desensitization protocol and is still unable to tolerate, or evidence of life-threatening reaction to TMP-SMX in the past (eg, toxic epidermal necrolysis, Stevens-Johnson syndrome). Malaria: Requests for coverage of any pyrimethamine products for the treatment and/or prophylaxis of malaria are not authorized and will not be approved. The use of pyrimethamine for the treatment and/or prophylaxis of malaria is not recommended by the Centers for Disease Control and Prevention (CDC).
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasmosis: Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Toxoplasmosis: 12 months
Other Criteria	N/A

DARZALEX (S)

Products Affected

- Darzalex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed/Refractory Multiple Myeloma (MM): Diagnosis of MM. One of the following: A) Both of the following: Used as monotherapy and One of the following: i) Patient has received at least three prior treatment regimens which included both a proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]) and an immunomodulatory agent (e.g., lenalidomide [Revlimid], thalidomide [Thalomid]) or ii) patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent. OR B) Patient has received at least one prior therapy (e.g., bortezomib [Velcade], carfilzomib [Kyprolis], ixazomib [Ninlaro], lenalidomide [Revlimid], thalidomide [Thalomid]). Darzalex will be used in combination with either 1) lenalidomide and dexamethasone or 2) bortezomib and dexamethasone or 3) carfilzomib and dexamethasone. OR C) Both of the following: used in combination with both pomalidomide and dexamethasone, AND patient has received at least two prior therapies including lenalidomide and a proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]). Newly Diagnosed Multiple Myeloma: Newly diagnosed multiple myeloma. One of the following: A) Both of the following: patient is ineligible for autologous stem cell transplant AND one of the following: 1) used in combination with all of the following: bortezomib, melphalan, and prednisone or 2) used in combination with both of the following: lenalidomide and dexamethasone. OR B) Both of the following: patient is eligible for autologous stem cell transplant AND used in combination with all of the following: bortezomib, thalidomide, and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

DAURISMO (S)

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute myeloid leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND Used in combination with low-dose cytarabine AND One of the following: 1) Patient is greater than or equal to 75 years old, or 2) Patient has comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

DEFERASIROX (S)

Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.
Age Restrictions	Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
Other Criteria	Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.

DEMSEER (S)

Products Affected

- Metyrosine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to both of the following: a) alpha-adrenergic blocker (e.g., phenoxybenzamine, doxazosin, terazosin) AND b) beta-adrenergic blocker (e.g., propranolol, metoprolol). Treatment of pheochromocytoma (initial): Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Patient with hormonally active (catecholamine excess) pheochromocytoma. One of the following: a) patient is not a candidate for surgery OR b) chronic treatment due to malignant pheochromocytoma. Patient has not reached normotension after treatment with a selective alpha-1-adrenergic blocker (e.g., doxazosin, terazosin) and beta-adrenergic blocker (e.g., propranolol, metoprolol). Medication will not be used to control essential hypertension.
Age Restrictions	N/A
Prescriber Restrictions	Preop prep: Prescribed by or in consultation with an endocrinologist OR Endocrine surgeon. Pheochromocytoma (initial): Prescribed by or in consultation with endocrinologist OR provider who specializes in the management of pheochromocytoma.
Coverage Duration	Preop prep: 4 wks. Treatment of pheo (initial): 6 months, (reauth): 12 months.
Other Criteria	Treatment of pheochromocytoma (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased frequency and severity of hypertensive attacks).

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

DIACOMIT (S)

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with clobazam. Patient weighs 7kg or more.
Age Restrictions	Patient is 6 months of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

DIBENZYLINE (S)

Products Affected

- Phenoxybenzamine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractionated metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to one of the following: a) doxazosin, or b) prazosin.
Age Restrictions	N/A
Prescriber Restrictions	Preop prep: prescribed by or in consultation with an endocrinologist or endocrine surgeon.
Coverage Duration	4 weeks
Other Criteria	N/A

DUPIXENT (S)

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-tx) peripheral blood eosinophil level greater than or equal to 150 cells/ml. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (eg, prednisone) within the past 12 mo, 2) Prior asthma-related hospitalization within the past 12 mo. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Patient is currently dependent on oral corticosteroids for the treatment of asthma. EA, CDA (init): One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (eg, greater than 100–200mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) or ii) One medium dosed combination ICS/LABA product (eg, Wixela Inhub [fluticasone propionate 100mcg/salmeterol50mcg], budesonide80mcg/formoterol4.5mcg, Breo Ellipta [fluticasone furoate 50mcg/vilanterol 25mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller medication [eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [eg, Wixela Inhub (fluticasone propionate 500mcg/salmeterol50mcg), budesonide160mcg/formoterol4.5mcg, Breo Ellipta (fluticasone200mcg/vilanterol25mcg)].

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Age Restrictions	AD (initial): Patient is 6 months or age or older. CRSwNP, PN: no age restriction. EoE (initial): Patient is at least 1 year of age.
Prescriber Restrictions	AD, PN (Init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. Asthma (init, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (init): Prescribed by or in consultation with a gastroenterologist or allergist/immunologist. COPD (init, reauth): Prescribed by or in consultation with a pulmonologist.
Coverage Duration	CRSwNP, EoE (Init/Reauth): 12 mo. Asthma, AD, PN, COPD (Init): 6 mo, (reauth): 12 mo.

Other Criteria	Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Dx of CRSwNP. Unless contraindicated, the patient (pt) has had an inadequate response to 2 mo of tx with an intranasal corticosteroid (CS) (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic esophagitis (EoE) (init): Dx of EoE. Pt has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, GERD/heartburn symptoms, chest pain, abdominal pain). Pt has at least 15 intraepithelial eosinophils per high power field. Other causes of esophageal eosinophilia have been excluded. Pt weighs at least 15 kg. Trial and failure, contraindication, or intolerance (TF/C/I) to at least an 8-wk trial of 1 of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) CS (eg, budesonide, fluticasone). PN (init): Diagnosis of PN. TF/C/I to 1 medium or higher potency topical CS (TCS). Atopic dermatitis (AD) (init): Dx of mod to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing AD (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for TCS), contraindication (CI) (eg, safety concerns, not indicated for pt's age/weight), or intolerance to 1 of the following: a) Medium or higher potency TCS, b) Pimecrolimus, c) Tacrolimus ointment, or d) Eucrisa (crisaborole). Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of type 2 inflammation evidenced by baseline blood eosinophils greater than or equal to 300 cells/mcL. Pt is receiving 1 of the following at maximally tolerated doses: triple therapy [ie, an ICS (eg, budesonide), a LAMA (eg, tiotropium, umeclidinium), and a LABA (eg, salmeterol, arformoterol, formoterol)] OR if CI to ICS, a LAMA and a LABA. Pt has had at least 2 exacerbations where systemic CS [IM/IV/oral (eg, prednisone)] were required at least once OR COPD-related hospitalization w/in the past 12 mo. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction in BSA involvement or SCORAD index value from baseline. EA, CDA, PN, CRSwNP, COPD (reauth): Pt demonstrates positive clinical response to therapy. EA, CDA (reauth): Pt continues to be treated with an ICS (e.g., fluticasone, budesonide) w/ or w/o additional asthma controller med (e.g., LTRA [e.g., montelukast], LABA [e.g., salmeterol], LAMA [e.g., tiotropium]) unless there is a C/I to these meds. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement of 1 of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures). COPD (reauth): Pt continues on triple therapy (ie, an ICS, a LAMA, and a LABA) OR if CI to ICS, a LAMA and a LABA.
------------------------------	---

ELAPRASE (S)

Products Affected

- Elaprase

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Hunter Syndrome (Mucopolysaccharidosis II (MPS II))
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ELIGARD (S)

Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

EMPLICITI (S)

Products Affected

- Empliciti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ENBREL (S)

Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.

ENDARI (S)

Products Affected

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. Patient has had 2 or more painful sickle cell crises within the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Sickle cell disease (initial, reauth): 12 months
Other Criteria	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.

ENJAYMO (S)

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cold agglutinin disease (CAD) based on ALL of the following: a) Presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count), b) Positive polyspecific direct antiglobulin test (DAT), c) Monospecific DAT strongly positive for C3d, d) Cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius, e) Direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1+ or less. Patient does not have cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders). Baseline hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL). One of the following: a) Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg OR b) Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months

Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by ALL of the following: a) The patient has not required any blood transfusions after the first 5 weeks of therapy with Enjaymo AND b) Hemoglobin level greater than or equal to 12 gram per deciliter (g/dL) or increased greater than or equal to 2 g/dL from baseline. One of the following: a) Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg OR b) Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater.
-----------------------	---

ENTYVIO (S)

Products Affected

- Entyvio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ulcerative Colitis (UC) (init): Diagnosis (Dx) of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Humira (adalimumab)/Cyltezo/or Yuflyma, Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Crohn's Disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to two of the following: Humira/Cyltezo/or Yuflyma, Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara, OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD (init): Prescribed by or in consultation with a gastroenterologist
Coverage Duration	UC, CD (init): 14 weeks. UC, CD (reauth): 12 months.
Other Criteria	UC, CD (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

ENTYVIO SC (s)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. CD, UC (initial): One of the following: a) Will be used as a maintenance dose following two doses of Entyvio IV for induction, or b) Patient is currently established on Entyvio IV.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 14 weeks. CD, UC (reauth): 12 months.
Other Criteria	CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

EPCLUSA PREFERRED (S)

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

EPIDIOLEX (S)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC.
Age Restrictions	LGS, DS, TSC: Patient is 1 year of age or older.
Prescriber Restrictions	LGS, DS, TSC: Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

EPOETIN ALFA (S)

Products Affected

- Epogen INJ 20000UNIT/ML
- Procrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon/peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa. Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	N/A
Coverage Duration	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 months is 33% or less (Hgb is 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Verify iron evaluation for adequate iron stores.

EPOPROSTENOL (S)

Products Affected

- Epoprostenol Sodium

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. (Reauth): 12 months
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ERBITUX (S)

Products Affected

- Erbitux

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.

ERIVEDGE (S)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Basal cell carcinoma: One of the following: A) Diagnosis of metastatic basal cell carcinoma OR B) Both of the following: 1) Diagnosis of locally advanced basal cell carcinoma AND 2) One of the following: a) Disease recurred following surgery or b) Patient is not a candidate for surgery and radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ERLEADA (S)

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ESBRIET (S)

Products Affected

- Pirfenidone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF.
Age Restrictions	N/A
Prescriber Restrictions	IPF (initial): Prescribed by or in consultation with a pulmonologist
Coverage Duration	initial, reauth: 12 months
Other Criteria	IPF (reauth): Patient demonstrates positive clinical response to therapy.

EVRYSDI (S)

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on both of the following: 1) Invasive ventilation or tracheostomy and 2) Use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Revised Upper Limb Module (RULM) Test (Non ambulatory), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Motor Function Measure 32 (MFM-32) Scale, or Item 22 of the Bayley Scales of Infant and Toddler Development Third Edition (BSID-III). Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
Age Restrictions	N/A
Prescriber Restrictions	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	Initial, Reauth: 12 months
Other Criteria	SMA (Reauth): Patient demonstrates positive clinical response to therapy. Pt is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) pt has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) pt has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).

EYLEA (S)

Products Affected

- Eylea

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Retinopathy of Prematurity (ROP) (initial): Diagnosis of ROP. One of the following: a) Patient gestational age at birth less than or equal to 32 weeks, OR b) Patient birth weight less than or equal to 1500 grams. Patient weight greater than 800 grams on day of treatment. ROP is present in at least one eye with one of the following classifications: a) ROP zone 1, stage 1 plus, 2 plus, 3, or 3 plus, b) ROP zone 2, stage 2 plus or 3 plus, OR c) AP-ROP (aggressive posterior ROP). All indications except ROP (initial): One of the following diagnoses: A) Neovascular (wet) age-related macular degeneration OR B) Macular edema following retinal vein occlusion, OR C) Diabetic macular edema OR D) Diabetic retinopathy. Trial and failure, contraindication, or intolerance to compounded bevacizumab prepared by a 503(B) Outsourcing Facility OR Lucentis (ranibizumab).
Age Restrictions	N/A
Prescriber Restrictions	All indications except ROP (initial): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases. ROP (initial, reauth): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	All indications (initial, reauth): 12 months
Other Criteria	All indications (reauth): Patient demonstrates positive clinical response to therapy

FABRAZYME (S)

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fabry Disease (init): Diagnosis of Fabry disease. One of the following: a) detection of pathogenic mutations in the GLA gene by molecular genetic testing, b) deficiency in α -galactosidase A (α -Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS), or c) significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata). Will not be used in combination with other drugs used for Fabry disease.
Age Restrictions	Fabry Disease (init): Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Fabry Disease (init, reauth): 12 months
Other Criteria	Fabry Disease (reauth): Patient demonstrates positive clinical response to therapy. Will not be used in combination with other drugs used for Fabry disease.

FASENRA (S)

Products Affected

- Fasenra

- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR 2) Prior asthma-related hospitalization within the past 12 months. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (e.g., greater than 100–200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) or ii) One medium dosed combination ICS/LABA product (e.g., Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/ formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [e.g., Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Age Restrictions	N/A
Prescriber Restrictions	Asthma (Initial/Reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. EGPA (initial): Prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist.
Coverage Duration	Asthma (init): 6 months. Asthma (reauth): 12 months. EGPA (init/reauth): 12 months.
Other Criteria	Eosinophilic granulomatosis with polyangiitis (EGPA) (Initial): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (ie, corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (eg, prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. Asthma (Reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. EGPA (reauth): Patient demonstrates positive clinical response to therapy.

FENTANYL (S)

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, Oral hydrocodone at a dose of greater than or equal to 60 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
Coverage Duration	12 months
Other Criteria	N/A

FERRIPROX (S)

Products Affected

- Deferiprone
- Ferriprox SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transfusional iron overload (Initial): Diagnosis of transfusional iron overload due to one of the following: thalassemia syndromes, sickle cell disease, or other transfusion-dependent anemias. Patient has Absolute Neutrophil Count (ANC) greater than $1.5 \times 10^9/L$. Trial and failure, contraindication or intolerance to one chelation therapy (e.g., generic deferasirox).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy. ANC greater than $1.5 \times 10^9/L$.

FINTEPLA (S)

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dravet Syndrome: Diagnosis of seizures associated with Dravet syndrome. Lennox-Gastaut Syndrome: Diagnosis of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	All Indications: Patient is 2 years of age or older.
Prescriber Restrictions	All Indications: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

FIRAZYR (S)

Products Affected

- Icatibant Acetate

- Sajazir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 18 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

FIRMAGON (S)

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

FOLOTYN (S)

Products Affected

- Folutyn
- Pralatrexate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

FOTIVDA (S)

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced renal cell carcinoma. Disease is one of the following: relapsed or refractory. Patient has received two or more prior systemic therapies (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

FRUZAQLA (S)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI), and B) Anti-VEGF biological therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-afigercept]). One of the following: A) Patient has RAS mutant tumors, OR B) Both of the following: a) Patient has RAS wild-type tumors, AND b) Patient has been previously treated with both of the following: 1) An anti-EGFR biological therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), and 2) One of the following: i) Lonsurf [trifluridine/tipiracil] or ii) Stivarga [regorafenib].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

GAMASTAN (S)

Products Affected

- Gamastan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune globulin is being used intramuscularly. The immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Patient requires immunization for hepatitis A, measles, rubella, or varicella.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

GATTEX (S)

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months.
Age Restrictions	SBS (initial): Patient is 1 year of age or older.
Prescriber Restrictions	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy.

GAVRETO (S)

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Presence of metastatic rearranged during transfection (RET) gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Thyroid Cancer: Diagnosis of thyroid cancer. Disease is one of the following: advanced or metastatic. Disease has presence of rearranged during transfection (RET) gene fusion-positive tumor(s). Disease requires treatment with systemic therapy. One of the following: patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.
Age Restrictions	Thyroid Cancer: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

GAZYVA (S)

Products Affected

- Gazyva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

GILENYA (S)

Products Affected

- Fingolimod Hydrochloride

- Gilenya CAPS 0.25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

GILOTRIF (S)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): A) Diagnosis of advanced or metastatic (stage IIIB or IV) NSCLC AND B) One of the following: 1) Both of the following: a) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy (e.g., cisplatin, carboplatin) and b) squamous NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

GLATIRAMER ACETATE (S)

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

GLEEVEC (S)

Products Affected

- Imatinib Mesylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+)/BCR ABL-positive chronic myelogenous leukemia (CML) OR B) Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease OR G) Aggressive systemic mastocytosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.

GLYCOPYRROLATE TABLET (S)

Products Affected

- Glycopyrrolate TABS 1MG, 2MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial, Reauth: 3 months.
Other Criteria	Reauth: One of the following: 1) Patient's peptic ulcer has not healed, OR 2) Patient has a new peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine). Patient experienced a reduction in peptic ulcer symptoms while on therapy.

GOMEKLI (S)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of neurofibromatosis type 1. Patient has plexiform neurofibromas that are both of the following: a) inoperable and b) causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

GROWTH HORMONE, NON-PREFERRED (S)

Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Omnitrope INJ 10MG/1.5ML, 5MG/1.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A

Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	All uses (initial): Trial and failure or intolerance to Genotropin. AGHD(initial): dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT], glucagon, macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD, IGHDA(reauth): monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. IGHDA(initial): doc GHD after 2 GH stim tests (ITT, glucagon, macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60, 90 mins after admin].

GROWTH HORMONE, PREFERRED (S)

Products Affected

- Genotropin

- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	AGHD(initial):dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30,45,60,90 mins after admin].

HAEGARDA (S)

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

HALAVEN (S)

Products Affected

- Eribulin Mesylate

- Halaven

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of recurrent or metastatic breast cancer. Previous treatment with both of the following: one anthracycline [eg, doxorubicin, Ellence (epirubicin)] and one taxane [eg, paclitaxel, Taxotere (docetaxel)]. Liposarcoma: Diagnosis of unresectable or metastatic liposarcoma. Previous treatment with one anthracycline-containing regimen (eg, doxorubicin, epirubicin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

HERCEPTIN (S)

Products Affected

- Herceptin INJ 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-overexpressing breast cancer. One of the following treatment regimens: a) As adjuvant treatment, b) metastatic disease and one of the following: 1) used in combination with a taxane (eg, docetaxel, paclitaxel), or 2) used as a single agent in a patient who has received one or more chemotherapy regimens for metastatic disease, or c) used in combination with Perjeta (pertuzumab). Gastric Cancer: Diagnosis of HER2-overexpressing gastric or gastroesophageal junction adenocarcinoma (locally advanced, recurrent, or metastatic). Used in combination with one of the following treatment regimens: a) Platinol (cisplatin) and Adrucil (5-fluorouracil), or b) Platinol (cisplatin) and Xeloda (capecitabine). All indications: One of the following: trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp), OR approve for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

HETLIOZ (S)

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-24-Hour Sleep-Wake Disorder (Non-24) (initial): Both of the following: 1) Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome), AND 2) patient is totally blind (has no light perception). Smith-Magenis Syndrome (SMS) (initial): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
Age Restrictions	SMS (initial): 16 years of age or older
Prescriber Restrictions	Non-24 (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist. SMS (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist.
Coverage Duration	Non-24, SMS (initial): 6 mo. (reauth): 12 mo
Other Criteria	Non-24, SMS (reauth): Patient demonstrates positive clinical response to therapy.

HUMIRA (S)

Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJI (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJI (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	--

HYDROXYPROGESTERONE (S)

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All uses (initial): Pregnant patients.
Required Medical Information	Amenorrhea/Abnormal Uterine Bleeding: Diagnosis of one of the following: 1) primary or secondary amenorrhea or 2) abnormal uterine bleeding. Amenorrhea or abnormal uterine bleeding is due to hormonal imbalance in the absence of organic pathology (e.g., submucous fibroids or uterine cancer). Secretory endometrium and desquamation: Used for production of secretory endometrium and desquamation in patients with endometrial disorder. Adenocarcinoma: Diagnosis of Stage III or IV adenocarcinoma of the uterine corpus. Estrogen production test: Used for the testing of endogenous estrogen production.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Amenorrhea/Abnormal Uterine Bleeding: 4 mo. Estrogen testing: 2 mo. All other uses: 12 months
Other Criteria	Approve for continuation of prior therapy.

IBRANCE (S)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ICLUSIG (S)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL). One of the following: a) Used in combination with chemotherapy up to 20 cycles OR b) Used as monotherapy in patients where one of the following applies: i) No other kinase inhibitors are indicated OR ii) Disease is T315I-positive Ph+ ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.

IDHIFA (S)

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Patient has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH2 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ILARIS (S)

Products Affected

- Ilaris INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Periodic Fever Syndromes (PFS) (Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever (FMF)). (Initial) Diagnosis of one of the autoinflammatory Periodic Fever Syndromes: CAPS (including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS)), TRAPS, HIDS/MKD, or FMF, AND The medication will not be used in combination with another biologic agent. Systemic juvenile idiopathic arthritis (sJIA) (Initial): Diagnosis of active sJIA. Still's Disease (Initial): Diagnosis of Still's Disease, including Adult-Onset Still's Disease (AOSD). SJIA, Still's Disease (initial): Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic corticosteroid (e.g., prednisone). Gout flares: Diagnosis of gout flares. Trial and failure, contraindication, or intolerance to TWO of the following: a) NSAIDs (e.g., ibuprofen, naproxen), b) colchicine, or c) corticosteroids (e.g., prednisone). Patient has not received Ilaris in the last 12 weeks.
Age Restrictions	N/A
Prescriber Restrictions	PFS (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, or neurologist. SJIA, Still's Disease (initial): Prescribed by or in consultation with a rheumatologist. Gout flares: Prescribed by or in consultation with a rheumatologist or nephrologist.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	PFS, SJIA, Still's disease (initial): 6 months, (reauth): 12 months. Gout flares: 12 weeks.
Other Criteria	PFS, Still's Disease (Reauth): Patient demonstrates positive clinical response to therapy. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline.

IMBRUVICA (S)

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD AND trial and failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate).
Age Restrictions	(cGVHD): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.

IMFINZI (S)

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): 1) Diagnosis of NSCLC AND 2) One of the following: a) All of the following: i) Disease is stage III, ii) unresectable, AND iii) Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy OR b) All of the following: i) Disease is metastatic, ii) Used in combination with Imjudo (tremelimumab-actl) and platinum-based chemotherapy (e.g., carboplatin, cisplatin), and iii) Disease has no sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) genomic tumor aberrations as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Small Cell Lung Cancer (SCLC): 1) Diagnosis of extensive-stage small cell lung cancer (ES-SCLC) AND 2) Used as first line treatment AND 3) Both of the following: a) Used in combination with Etoposide and b) Used in combination with carboplatin or cisplatin. Biliary Tract Cancer (BTC): 1) Diagnosis of biliary tract cancer AND 2) Disease is one of the following: a) Locally advanced OR b) Metastatic AND 3) Used in combination with gemcitabine and cisplatin. Hepatocellular Carcinoma (HCC): Diagnosis of unresectable hepatocellular carcinoma (uHCC). Used in combination with Imjudo (tremelimumab-actl).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

IMKELDI (S)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) CML. Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Ph+/BCR ABL+ ALL. Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD): Diagnosis of MDS/MPD. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: a) HES or b) CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

INCRELEX (S)

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	(Reauth): Patient demonstrates positive clinical response to therapy.

INFLECTRA (S)

Products Affected

- Inflectra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (eg, prednisone), methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	RA, AS: Prescribed by or in consultation with a rheumatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist. CD, FCD, UC: Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	Ankylosing spondylitis (AS) (initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (initial): Dx of sarcoidosis. TF/C/I to one of the following: corticosteroid (eg, prednisone) OR immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine). All indications (initial): Trial and failure or intolerance to Remicade or Infliximab. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (reauth): Patient demonstrates positive clinical response to therapy.

INGREZZA (S)

Products Affected

- Ingrezza CAPS
- Ingrezza CPSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease (initial): Diagnosis of chorea in patients with Huntington's disease.
Age Restrictions	N/A
Prescriber Restrictions	Tardive Dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	All Uses (initial): 3 months. All Uses (reauth): 12 months
Other Criteria	All Uses (reauth): Patient demonstrates positive clinical response to therapy.

INLYTA (S)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: (1) used as first-line treatment in combination with avelumab or pembrolizumab or (2) used after failure of one prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

INQOVI (S)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic syndrome (MDS): Diagnosis of myelodysplastic syndrome. Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

INREBIC (S)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

IRESSA (S)

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ISTODAX (S)

Products Affected

- Romidepsin INJ 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ITOVEBI (S)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: a) Locally advanced, or b) Metastatic. Disease is all of the following (as detected by a U.S. Food and Drug Administration [FDA]-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments [CLIA]): a) PIK3CA-mutated, b) Hormone receptor (HR)-positive, c) Human epidermal growth-factor receptor 2 (HER2)-negative. Used following recurrence on or after completing adjuvant endocrine therapy (e.g. Zoladex [goserelin], Arimidex [anastrozole], Nolvadex [tamoxifen]). Used in combination with both of the following: a) Ibrance (Palbociclib), and b) Fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ITRACONAZOLE CAPSULE (S)

Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infection (SFI): Diagnosis of a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis). Fingernail Onychomycosis: Diagnosis of fingernail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine. Toenail Onychomycosis: Diagnosis of toenail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SFI:6mo.Fingernail Onychomycosis:5wks.Toenail Onychomycosis:3mo.
Other Criteria	N/A

ITRACONAZOLE SOLUTION (S)

Products Affected

- Itraconazole SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Candidiasis: Diagnosis of esophageal or oropharyngeal candidiasis. One of the following: i) Trial and failure, contraindication, or intolerance to fluconazole OR ii) Susceptibility results demonstrate resistance to fluconazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Candidiasis: 1 month
Other Criteria	N/A

IVERMECTIN (S)

Products Affected

- Ivermectin TABS 3MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	N/A

IVIG (s)

Products Affected

- Bivigam INJ 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 5GM/100ML, 5GM/50ML
- Privigen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A

Required Medical Information	Initial: Immune globulin (Ig) will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. For IVIG – Ig is being used intravenously (IV) AND One of the following diagnoses: [A] Primary Immunodeficiency 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). [B] Secondary Acquired Antibody Deficiency 1) B-cell chronic lymphocytic leukemia with an Ig level less than 500 mg/dL OR history of recurrent bacterial infections. 2) HIV infection with an Ig level less than 400 mg/dL OR Patient has active bleeding or a platelet count less than $10 \times 10^9/L$. 3) Multiple myeloma in plateau phase and patient has hypogammaglobulinemia. [C] Hematological Autoimmune Disorders 1) Acquired (pure) red cell aplasia (PRCA) that is immunologic and patient had a trial and failure, contraindication, or intolerance (TF/C/I) to a corticosteroid and an immunosuppressant (i.e., cyclophosphamide, cyclosporine) OR patient has viral PRCA caused by parvovirus B19. 2) Fetal alloimmune thrombocytopenia. 3) Hemolytic disease of the newborn and the patient has established hyperbilirubinemia. 4) Idiopathic thrombocytopenic purpura and patient had a TF/C/I to a corticosteroid OR a platelet count less than 30,000 cells/mm ³ . Continued in Other Criteria Section.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist).
Coverage Duration	4 months: Solid organ transplant. 12 months: all other diagnoses.

Other Criteria	[D] Neuromuscular Autoimmune Disorders 1) Chronic inflammatory demyelinating polyneuropathy. 2) Guillain-Barré syndrome. 3) Inflammatory myopathies (dermatomyositis or polymyositis) AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus). 4) Lambert-Eaton myasthenic syndrome AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (e.g., azathioprine). 5) Multifocal motor neuropathy. 6) Myasthenia gravis with severe exacerbations or myasthenic crises. 7) Stiff person syndrome AND Patient had a TF/C/I to at least 2 standard therapies (i.e., benzodiazepines, muscle relaxants, or anti-convulsants). [E] Other Disorders 1) Autoimmune blistering disease AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., cyclophosphamide, dapsone, methotrexate, azathioprine, or mycophenolate mofetil). 2) Kawasaki syndrome. 3) Solid organ transplant and IVIG is being used for CMV prophylaxis, or patient is a kidney transplant recipient and has donor specific antibodies, or patient has steroid-resistant rejection and had a TF/C/I to standard therapies. For SCIG (Gamunex-C, Gammagard Liquid, Gammaked only)- Immune globulin is being used subcutaneously AND One of the following PI diagnoses: 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). All products: Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. For non-oncology renewal, the patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.
------------------------------	---

IWILFIN (S)

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of high-risk neuroblastoma (HRNB). Patient has shown at least a partial response to prior multiagent, multimodality therapy. Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

JAKAFI (S)

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND trial and failure, contraindication, or intolerance to hydroxyurea. Acute graft versus host disease (aGVHD): Diagnosis of aGVHD. Disease is steroid-refractory. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD. Trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.

JAYPIRCA (S)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior therapies for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Brukinsa (zanubrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Patient has received treatment for CLL/SLL with both of the following therapies: a) BTK inhibitor therapy [e.g., Calquence (acalabrutinib), Brukinsa (zanubrutinib)], and b) B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

JEVTANA (S)

Products Affected

- Jevtana

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of castration-resistant metastatic prostate cancer AND patient has been previously treated with a docetaxel-containing regimen AND patient is receiving concurrent prednisone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

JUXTAPID (S)

Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 400 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. One of the following: a) patient is receiving other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Trial and failure, contraindication, or intolerance to Repatha therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): 12 months
Other Criteria	HoFH (reauthorization): One of the following: a) patient continues to receive other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Submission of medical records (eg, chart notes, laboratory values) documenting LDL-C reduction from baseline while on therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

JYLAMVO (S)

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neoplastic diseases: Diagnosis of one of the following: A) acute lymphoblastic leukemia (ALL), B) mycosis fungoides (cutaneous T-cell lymphoma), or C) relapsed or refractory non-hodgkin lymphomas. Rheumatoid arthritis (RA): Diagnosis of RA. Psoriasis: Diagnosis of severe psoriasis. Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist. Psoriasis: Prescribed by or in consultation with a dermatologist. pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Neoplastic diseases, RA, Psoriasis, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.

KADCYLA (S)

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KALBITOR (S)

Products Affected

- Kalbitor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. For the treatment of acute HAE attacks. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: 12 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

KALYDECO (S)

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of cystic fibrosis. Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (initial): Patient is 1 month of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient demonstrates positive clinical response (i.e. improvement in lung function [percent predicted forced expiratory volume in one second (PPFEV1)], decreased number of pulmonary exacerbations) while on therapy.

KANUMA (S)

Products Affected

- Kanuma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of lysosomal acid lipase deficiency (e.g., LAL-D, Wolman Disease, Cholesteryl ester storage disease). Diagnosis was confirmed by one of the following: a) enzymatic blood test (e.g., dried blood spot test) demonstrating a deficiency of LAL enzyme activity, OR b) genetic testing for mutations in the Lipase A, Lysosomal Acid Type (LIPA) gene.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a specialist experienced in the treatment of inborn errors of metabolism, gastroenterologist, or lipidologist
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

KERENDIA (S)

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D). Urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g. Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m ² . Serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. One of the following: 1) Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following: a) generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. One of the following: 1) Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months

Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB, OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. One of the following: 1) Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
-----------------------	---

KEYTRUDA (S)

Products Affected

- Keytruda INJ 100MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KINERET (S)

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID AND dx of NOMID has been confirmed by one of the following: 1) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3) gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation OR 2) Both of the following: a) two of the following clinical symptoms: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia), chronic aseptic meningitis, or skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing) AND b) elevated acute phase reactants (eg, erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA]). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.
Coverage Duration	RA, NOMID (initial): 6 months, (reauth): 12 months. DIRA: 12 months.

Other Criteria	RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (reauth): Patient demonstrates positive clinical response to therapy.
-----------------------	---

KISQALI (S)

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

KISQALI-FEMARA PACK (S)

Products Affected

- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KORLYM (S)

Products Affected

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's syndrome (Initial): Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	Reauth: Patient demonstrates one of the following: patient has improved glucose tolerance while on therapy or patient has stable glucose tolerance while on therapy.

KOSELUGO (S)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment). Patient is able to swallow a capsule whole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KRAZATI (S)

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: locally advanced or metastatic. Disease is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Colorectal Cancer (CRC): Diagnosis of CRC. Disease is one of the following: locally advanced or metastatic. Tumor is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA) -approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Erbitux (cetuximab). Patient has received prior treatment with ALL of the following: a) fluoropyrimidine-based chemotherapy, b) oxaliplatin-based chemotherapy, and c) irinotecan-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KUVAN (S)

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy. Patient will continue to have blood Phe levels measured periodically during therapy.

KYPROLIS (S)

Products Affected

- Kyprolis INJ 30MG, 60MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LANREOTIDE (S)

Products Affected

- Lanreotide Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly: Diagnosis of acromegaly. One of the following: A) Inadequate response to one of the following: surgery or radiotherapy, OR B) Not a candidate for one of the following: surgery or radiotherapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (120mg/0.5mL strength only): Diagnosis of GEP-NETs. Disease is one of the following: (a) unresectable, locally advanced or (b) metastatic. Carcinoid syndrome (120mg/0.5mL strength only): Diagnosis of carcinoid syndrome. Used to reduce the frequency of short-acting somatostatin analog rescue therapy.
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist. Carcinoid syndrome (initial): Prescribed by or in consultation with an endocrinologist or oncologist.
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

LAZCLUZE (S)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Used as first line treatment of NSCLC. Used in combination with Rybrevant (amivantamab). Presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LEMTRADA (S)

Products Affected

- Lemtrada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Patient has not been previously treated with alemtuzumab, and trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod)] or 2) Patient has previously received treatment with alemtuzumab, and at least 12 months have or will have elapsed since the most recent treatment course with alemtuzumab. Not used in combination with another disease-modifying therapy for MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist
Coverage Duration	MS: 12 months.
Other Criteria	N/A

LENVIMA (S)

Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Renal Cell Carcinoma (RCC): Diagnosis of RCC. One of the following: 1) Both of the following: a) Used as first-line treatment and b) Used in combination with Keytruda (pembrolizumab), or 2) Both of the following: a) Treatment follows one prior anti-angiogenic therapy and b) Used in combination with everolimus. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Endometrial Carcinoma (EC): Diagnosis of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H), or mismatch repair deficient (dMMR) [i.e. disease is mismatch repair proficient (pMMR)]. Patient has disease progression following systemic therapy. Used in combination with Keytruda (pembrolizumab) therapy. Patient is not a candidate for curative surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LETAIRIS (S)

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

LIDOCAINE TOPICAL (S)

Products Affected

- Glydo
- Lidocaine OINT 5%
- Lidocaine Hcl PRSY
- Lidocaine Hcl Jelly PRSY
- Lidocaine Hydrochloride EXTERNAL SOLN
- Lidocaine Hydrochloride Jelly
- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

LIDODERM (S)

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LIVMARLI (S)

Products Affected

- Livmarli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alagille syndrome (ALGS) (initial): Both of the following: a) Diagnosis of ALGS, and b) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene. Patient has had an inadequate response to one of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Welchol). Progressive Familial Intrahepatic Cholestasis (PFIC) (init): Both of the following: a) Diagnosis of PFIC, and b) Molecular genetic testing confirms mutations in the ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, or MYO5B gene. Patient has had an inadequate response to one of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Welchol).
Age Restrictions	ALGS (initial): Patient is 3 months of age or older. PFIC (init): Patient is 12 months of age or older.
Prescriber Restrictions	All indications (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	ALGS (initial, reauth): 12 months. PFIC (init): 6 months, (reauth): 12 months.
Other Criteria	All indications (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score).

LONSURF (S)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND One of the following: Used as a single agent or Used in combination with bevacizumab AND Patient has been previously treated with both of the following: A) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND B) anti-VEGF therapy (e.g., Avastin [bevacizumab]) AND One of the following: A) patient has RAS wild-type tumors and patient has been previously treated with one anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]) OR Patient has RAS mutant tumors. Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Patient has been previously treated with two of the following: fluoropyrimidine-based chemotherapy (e.g. fluorouracil), Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LORBRENA (S)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LOTRONEX (S)

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Severe Diarrhea-Predominant Irritable Bowel Syndrome (IBS) in Women (initial): All of the following: 1) diagnosis of severe diarrhea-predominant IBS, 2) symptoms for at least 6 months, 3) female patient, AND 4) trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	Initial: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	IBS (initial): 12 weeks. IBS (reauth): 6 mo.
Other Criteria	IBS (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy (e.g., relief of IBS abdominal pain and discomfort, improvement in stool consistency and frequency, improvement as measured by the Global Improvement Scale).

LUMAKRAS (S)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced or b) metastatic. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior therapy with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy. Used in combination with Vectibix (panitumumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LUMIZYME (S)

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Infantile Onset Pompe Disease (IOPD) (initial): Diagnosis of IOPD (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: 1) Absence or deficiency (less than 1% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay, OR 2) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., cardiomegaly, hypotonia, etc.). Late Onset Pompe Disease (LOPD) (initial): Diagnosis of LOPD (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: 1) Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay, OR 2) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.).
Age Restrictions	IOPD (initial): Patient is less than or equal to 12 months of age. LOPD (initial): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	IOPD, LOPD (initial, reauth): 12 months
Other Criteria	IOPD, LOPD (reauth): Patient demonstrates positive clinical response to therapy.

LUPRON (S)

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 months
Other Criteria	Approve for continuation of prior therapy.

LUPRON DEPOT (S)

Products Affected

- Lupron Depot (1-month)
- Lupron Depot (3-month)

- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Diagnosis of advanced or metastatic prostate cancer. Endometriosis (3.75 mg, 11.25 mg): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or trial and failure, contraindication, or intolerance to one NSAID (e.g., diclofenac, ibuprofen, meloxicam, naproxen) and one oral contraceptive (e.g., norethindrone-ethinyl estradiol, estradiol and norethindrone). Uterine Leiomyomata (UL) (3.75 mg, 11.25 mg): a) For use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) OR b) all of the following: treatment of anemia, anemia is caused by uterine leiomyomata (fibroids), and for use prior to surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 mo. Endomet:6mo. UL (anemia):3 mo (fibroids):4 mo
Other Criteria	Approve for continuation of prior therapy.

LUPRON DEPOT PED (S)

Products Affected

- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Lupron Depot-ped (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy. Patient is currently younger than the appropriate time point for the onset of puberty (e.g., females younger than 11 years of age, males younger than 12 years of age).

LYNPARZA TABLET (S)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Prostate cancer: Diagnosis of castration-resistant prostate cancer. All indications: Approve for continuation of prior therapy.

LYTGOBI (S)

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of intrahepatic cholangiocarcinoma. Disease is one of the following: a) unresectable, b) locally advanced, or c) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. Patient has been previously treated (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

MARINOL (S)

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 3 months.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.

MAVYRET (S)

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: 1) One of the following: a) Diagnosis of chronic hepatitis C (CHC), or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of CHC, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	8 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

MEKINIST (S)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E or V600K mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Tafenlar (dabrafenib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Tafenlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic ATC. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Tafenlar (dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafenlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafenlar (dabrafenib).
-----------------------	--

MEKTOVI (S)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

MIGRANAL (S)

Products Affected

- Dihydroergotamine Mesylate
NASAL SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).

MIRVASO (S)

Products Affected

- Brimonidine Tartrate GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rosacea (init): Diagnosis of rosacea. Patient has moderate to severe persistent (nontransient) facial erythema.
Age Restrictions	Rosacea (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Rosacea (init, reauth): 12 months
Other Criteria	Rosacea (reauth): Patient demonstrates positive clinical response to therapy.

MOUNJARO (S)

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

MS INTERFERONS (NON-PREFERRED) (S)

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to one of the following: Avonex (interferon beta-1a) or Betaseron (interferon beta-1b), or 2) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

MS INTERFERONS (PREFERRED) (S)

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen
- Betaseron
- Extavia
- Plegridy
- Plegridy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

MYALEPT (S)

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy. One of the following: 1) Diabetes mellitus or insulin resistance despite insulin therapy at maximum tolerated doses OR 2) Hypertriglyceridemia.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Lipodystrophy (reauth): Patient demonstrates positive clinical response to therapy.

MYLOTARG (S)

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute myeloid leukemia (AML): One of the following diagnoses: Newly diagnosed AML or relapsed/refractory (R/R) AML. Disease is CD33-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NAGLAZYME (S)

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis (MPS VI): Diagnosis of MPS VI (Maroteaux-Lamy Syndrome).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MPS VI: 12 months
Other Criteria	N/A

NERLYNX (S)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Early Stage Breast cancer: Diagnosis (dx) of early stage breast cancer. Advanced or Metastatic Breast Cancer: Dx of advanced or metastatic breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NEULASTA (S)

Products Affected

- Neulasta

- Neulasta Onpro Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

NEXAVAR (S)

Products Affected

- Sorafenib

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC. One of the following: locally recurrent disease, or metastatic disease. Patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NINLARO (S)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NORTHERA (S)

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurogenic orthostatic hypotension (NOH) (init): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial and failure, contraindication, or intolerance to one of the following agents: fludrocortisone acetate, midodrine.
Age Restrictions	N/A
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist
Coverage Duration	NOH (init): 1 month (reauth): 12 months
Other Criteria	NOH (reauth): Patient demonstrates positive clinical response to therapy.

NOVANTRONE (S)

Products Affected

- Mitoxantrone Hcl INJ 2MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis (dx) of one of the following: secondary progressive MS: gradually worsening disability with or without superimposed relapses, progressive relapsing MS: progression of disability from the onset with superimposed relapses, or worsening relapsing-remitting MS: neurological status remains significantly abnormal in between MS relapses. Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS (e.g., Gilenya [fingolimod], Avonex [interferon beta-1a], Betaseron [interferon beta-1b]). Left ventricular ejection fraction (LVEF) greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm ³ . Lifetime cumulative dose less than 140 mg/m ² . Prostate Cancer (PC): Dx of advanced hormone-refractory (castration-resistant) PC. Used in combination with corticosteroids (eg, prednisone, methylprednisolone). LVEF greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm ³ . Acute Non-Lymphocytic Leukemia (ANLL): Dx of ANLL (eg, myelogenous, promyelocytic, monocytic, and erythroid). Used in combination with other medications used for the treatment of ANLL. LVEF greater than or equal to 50%.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Uses: 6 months
Other Criteria	Approve for continuation of prior therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

NOXAFIL SUSPENSION (S)

Products Affected

- Posaconazole SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Oropharyngeal Candidiasis (OPC): Diagnosis of OPC. One of the following: 1) Trial and failure, contraindication, or intolerance to fluconazole OR 2) Susceptibility results demonstrate resistance to fluconazole.
Age Restrictions	Prophylaxis of SFI, OPC: Patient is 13 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months. OPC: 1 month.
Other Criteria	N/A

NPLATE (S)

Products Affected

- Nplate INJ 250MCG, 500MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune thrombocytopenia (ITP): Diagnosis of one of the following: a) ITP or b) relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., dexamethasone, prednisone), immune globulins (e.g., Gammaplex, Gammagard S/D), or splenectomy. Hematopoietic syndrome of acute radiation syndrome: Diagnosis of hematopoietic syndrome of acute radiation syndrome. Patient is acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial), Hematopoietic syndrome of acute radiation syndrome: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP (initial, reauth): 12 months. Hematopoietic syndrome of acute radiation syndrome: 14 days.
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.

NUBEQA (S)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Hormone-sensitive prostate cancer (HSPC): Diagnosis of HSPC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, HSPC: 12 months
Other Criteria	Approve for continuation of prior therapy.

NUCALA (S)

Products Affected

- Nucala INJ 100MG, 40MG/0.4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by one of the following: baseline(pre-tx) peripheral blood eosinophil level is greater than or equal to 150cells/ml or peripheral blood eosinophil levels were greater than or equal to 300cells/ml within the past 12 mo. Patient has had two or more asthma exacerbations requiring systemic corticosteroids(eg, prednisone) within the past 12 mo or Patient has had a prior asthma-related hospitalization within the past 12 mo. One of the following: 1)Both of the following: a)Patient is 6 years of age or older but less than 12 years of age b)Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i)Medium-dose inhaled corticosteroid[ICS](eg, greater than 100–200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]) or ii)One medium dosed combination ICS/LABA product (eg, Wixela Inhub[fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a)Both of the following: i)High-dose ICS(eg, greater than 500 mcg fluticasone propionate equivalent/day) and ii)additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]), OR b)One maximally-dosed combination ICS/LABA product(eg, Wixela Inhub[fluticasone propionate 500mcg/salmeterol 50mcg], budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone 200mcg/vilanterol 25mcg])

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Age Restrictions	N/A
Prescriber Restrictions	Asthma (init, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist.
Coverage Duration	Asthma (init): 6 mo, Asthma (reauth): 12 months. CRSwNP, EGPA, HES (init, reauth): 12 months
Other Criteria	Hypereosinophilic Syndrome (HES) (init): Diagnosis of HES. Patient has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is FIP1L1-PDGfra-negative. Patient has uncontrolled HES defined as both of the following: a) History of 2 or more flares within the past 12 months AND b) Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication, or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). Asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Patient demonstrates positive clinical response to therapy.

NUEDEXTA (S)

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. Patient does not have any of the following contraindications: a) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block.
Age Restrictions	N/A
Prescriber Restrictions	PBA (initial): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist.
Coverage Duration	PBA (initial/reauth): 12 months
Other Criteria	PBA (reauth): Patient demonstrates clinical benefit from ongoing therapy as demonstrated by a decrease in inappropriate laughing or crying episodes.

NUPLAZID (S)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NUVIGIL (S)

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: 12 mo

Other Criteria	OSA, Narcolepsy (Reauth): Patient demonstrates positive clinical response to armodafinil therapy. SWD (Reauth): Patient demonstrates positive clinical response to armodafinil therapy.
-----------------------	---

OCALIVA (S)

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Biliary Cholangitis (PBC) (initial): Diagnosis of PBC (aka primary biliary cirrhosis). One of the following: a) patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND used in combination with UDCA, OR b) contraindication or intolerance to UDCA. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).
Age Restrictions	N/A
Prescriber Restrictions	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	PBC (initial): 6 months, (reauth): 12 months
Other Criteria	PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in ALP level from pre-treatment baseline (ie, prior obeticholic acid therapy) while on therapy. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).

ODOMZO (S)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma AND One of the following: 1) Cancer has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OFEV (S)

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD as documented by all of the following: a) exclusion of other known causes of ILD (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on HRCT revealing SSc-ILD or probable SSc-ILD, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype (initial): 1) diagnosis of chronic fibrosing interstitial lung disease, AND 2) patient has a high-resolution computed tomography (HRCT) showing at least 10% of lung volume with fibrotic features, AND 3) disease has a progressive phenotype as observed by one of the following: decline of forced vital capacity (FVC), worsening of respiratory symptoms, or increased extent of fibrosis seen on imaging.
Age Restrictions	N/A
Prescriber Restrictions	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (initial): Prescribed by or in consultation with a pulmonologist

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	Initial, reauth: 12 months
Other Criteria	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (reauth): Patient demonstrates positive clinical response to therapy.

OGSIVEO (S)

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OJEMDA (S)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OJJAARA (S)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Patient has anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ONPATTRO (S)

Products Affected

- Onpattro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Patient has a transthyretin (TTR) mutation (e.g., V30M). Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, or a baseline neuropathy impairment score (NIS) between 5 and 130. Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy).
Age Restrictions	N/A
Prescriber Restrictions	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	hATTR amyloidosis (initial, reauth): 12 months
Other Criteria	Subject to Part B vs D review. hATTR amyloidosis (reauth): Patient demonstrates positive clinical response to therapy.

ONUREG (S)

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML). Patient has received previous treatment with an intensive induction chemotherapy regimen (e.g., cytarabine + daunorubicin, cytarabine + idarubicin, etc.). Patient has achieved one of the following: a) first complete remission (CR) or b) complete remission with incomplete blood count recovery (CRi). Patient is not able to complete intensive curative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OPDIVO (S)

Products Affected

- Opdivo INJ 100MG/10ML, 40MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OPIPZA (S)

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of Schizophrenia. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: a) aripiprazole (failure or contraindication are not required), b) olanzapine, c) quetiapine IR/ER, d) risperidone, e) clozapine, f) ziprasidone, g) paliperidone, or h) asenapine. Major Depressive Disorder (MDD): Diagnosis of MDD. Both of the following: a) TF/C/I to quetiapine IR/ER and b) trial of or intolerance to aripiprazole. Autism: Diagnosis of irritability associated with autistic disorder. Both of the following: a) trial and failure, contraindication (e.g., age), or intolerance to risperidone and b) trial of or intolerance to aripiprazole. Tourette's Syndrome: Diagnosis of Tourette's Syndrome. Trial of or intolerance to aripiprazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OPSUMIT (S)

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ORENCIA IV (S)

Products Affected

- Orencia INJ 250MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Acute graft versus host disease (aGVHD): Used for prophylaxis of aGVHD. Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT. Used in combination with both of the following: calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate.
Age Restrictions	aGVHD: Patient is 2 years of age or older
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	RA, JIA, PsA (initial): 6 months, (reauth): 12 months. aGVHD: 2 months

Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.
-----------------------	---

ORENCIA SC (S)

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML

- Orencia Clickject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months

Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.
-----------------------	---

ORENITRAM (S)

Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ORGOVYX (S)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ORKAMBI (S)

Products Affected

- Orkambi TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (Initial): Patient is 6 years of age or older
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

ORKAMBI GRANULES (S)

Products Affected

- Orkambi PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.
Age Restrictions	N/A
Prescriber Restrictions	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.

ORSERDU (S)

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor (ESR1) mutation(s) as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OSPHERA (S)

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Patient demonstrates positive clinical response to therapy.

OTEZLA (S)

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, OR calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).

OXLUMO (S)

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Hyperoxaluria Type 1 (PH1) (initial): Diagnosis of PH1. Diagnosis has been confirmed by both of the following: 1) One of the following: a) Elevated urinary oxalate excretion, b) Elevated plasma oxalate concentration, or c) Spot urinary oxalate to creatinine molar ratio greater than normal for age, AND One of the following: 1) Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene OR 2) Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity.
Age Restrictions	N/A
Prescriber Restrictions	PH1 (initial, reauth): Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
Coverage Duration	PH1 (initial, reauth): 12 months.
Other Criteria	PH1 (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration).

OZEMPIC (S)

Products Affected

- Ozempic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by one of the following: FibroScan-aspartate aminotransferase (FAST), MRI-aspartate aminotransferase (MAST), or liver biopsy. Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: FibroScan, Fibrosis-4 index (FIB-4), or Magnetic Resonance Elastography (MRE).
Age Restrictions	N/A
Prescriber Restrictions	MASH (Initial): Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	12 months
Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates positive response to therapy.

PEGASYS (S)

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection. Chronic Hepatitis C: Diagnosis of chronic hepatitis C infection. Patient has compensated liver disease. One of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin).
Age Restrictions	N/A
Prescriber Restrictions	Chronic Hepatitis C: Prescribed by or in consultation with one of the following: hepatologist, gastroenterologist, infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	HepB, HepC: 48 wks.
Other Criteria	N/A

PEMAZYRE (S)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced or metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has been previously treated. Myeloid/lymphoid neoplasms: Diagnosis of myeloid/lymphoid neoplasms (MLNs). Disease is relapsed or refractory. Disease has presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

PENNSAID (S)

Products Affected

- Diclofenac Sodium EXTERNAL SOLN 1.5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Osteoarthritis of the knees (initial): Diagnosis of osteoarthritis of the knees. Patient meets one of the following: 1) Treatment failure with at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen) OR 2) History of peptic ulcer disease/gastrointestinal bleed OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Osteoarthritis of the knees (reauth): Patient demonstrates positive clinical response to therapy (e.g., improvement in pain symptoms of osteoarthritis).

PERJETA (S)

Products Affected

- Perjeta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

PIQRAY (S)

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer (BC): Diagnosis of advanced or metastatic BC. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Cancer is PIK3CA-mutated as detected by an FDA-approved test (therascreen PIK3CA RGQ PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

POMALYST (S)

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM): Diagnosis of MM. Kaposi sarcoma (KS): One of the following: 1) Diagnosis of AIDS-related KS, OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

PORTRAZZA (S)

Products Affected

- Portrazza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

POSACONAZOLE TABLET (S)

Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment (Tx) of SFI: Used as treatment of systemic fungal infections caused by Aspergillus.
Age Restrictions	Prophylaxis of SFI: Patient is 2 years of age or older. Tx of SFI: Patient is 13 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months. Tx of SFI: 3 months.
Other Criteria	N/A

PRALUENT (S)

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD (init): One of the following dx: A)HeFH, B)ASCVD, OR C)Primary hyperlipidemia (HLD). One of the following: 1)Pt has been receiving highest tolerable dose of statin therapy, OR (2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR (3) Pt has an FDA labeled contraindication to all statins. ONE of the following: a) One of the following LDL values while on max tolerated lipid lowering regimen w/in the last 120 days: (1) Patient requires greater than or equal to 25% LDL-C reduction to achieve goal, (2) LDL greater than or equal to 55 mg/dL w/ ASCVD, or (3) LDL greater than or equal to 70 mg/dL w/o ASCVD. OR b) Both of the following: (1) Patient has been receiving PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe) and (2) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering therapy is within normal limits. HoFH (init): Dx of HoFH as confirmed by one of the following: 1)Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2)either untreated/pre-treatment LDL greater than 400 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents. One of the following: 1)Pt is receiving other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe).
Age Restrictions	HeFH (Initial): Patient is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) at max tolerated dose (unless pt has documented inability to take these medications). HoFH (reauth): One of the following: 1)Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.
-----------------------	---

PROCYSBI (S)

Products Affected

- Procysbi CPDR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nephropathic cystinosis: Diagnosis of nephropathic cystinosis, confirmed by elevated leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene or demonstration of cysteine corneal crystals by slit lamp examination AND Trial and failure or intolerance to therapy with Cystagon (immediate-release cysteamine bitartrate).
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PROMACTA (S)

Products Affected

- Eltrombopag Olamine

- Promacta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of one of the following: relapsed/refractory ITP, persistent ITP, or chronic ITP. Baseline platelet count is less than 30,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. Trial and failure, intolerance, contraindication to corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C-associated thrombocytopenia. One of the following: 1) Planning to initiate and maintain interferon-based treatment, or 2) currently receiving interferon-based treatment. First-line for severe aplastic anemia (SAA): Diagnosis of SAA. Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy). Used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine). Patient meets at least two of the following: 1) absolute neutrophil count less than 500/mcL, 2) platelet count less than 20,000/mcL, 3) absolute reticulocyte count less than 60,000/mcL. Refractory SAA (initial): Diagnosis of refractory severe aplastic anemia. Patient has a platelet count less than 30,000/mcL. Insufficient response to immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	ITP and SAA: Prescribed by or in consultation with a hematologist/oncologist. Chronic hepatitis C associated thrombocytopenia: Prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	ITP(init, reauth): 12mo. HepC: 3mo(init), 12mo(reauth). 1st line SAA: 6mo. Refract SAA: 16wk-init, 12mo-reauth
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hepatitis C (reauth): One of the following: 1) For patients that started treatment with eltrombopag prior to initiation of treatment with interferon, eltrombopag will be approved when both of the following are met: a) Currently on antiviral interferon therapy for treatment of chronic hepatitis C and b) Documentation that the patient reached a threshold platelet count that allows initiation of antiviral interferon therapy with eltrombopag treatment by week 9, OR 2) For patients that started treatment with eltrombopag while on concomitant treatment with interferon, eltrombopag will be approved based on the following: Currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count.

PROVIGIL (S)

Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial): Dx of SWD confirmed by one of the following: 1) Symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy. Idiopathic Hypersomnia (Initial): Diagnosis of idiopathic hypersomnia as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy: Init, Reauth: 12 mo. All other indications: Init, Reauth: 6 mo.
Other Criteria	OSA, Narcolepsy, Idiopathic Hypersomnia (Reauth): Patient demonstrates positive clinical response to modafinil therapy. SWD (Reauth): Patient demonstrates positive clinical response to modafinil therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Depression (reauth): Patient demonstrates positive clinical response to modafinil therapy. Used as adjunctive therapy.

PULMOZYME (S)

Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

PYRUKYND (S)

Products Affected

- Pyrukynd

- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count). Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene: a) Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant AND b) Patients is not homozygous for the c.1436G to A (p.R479H) variant AND c) Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene. Hemoglobin is less than or equal to 10g/dL. Patient has symptomatic anemia or is transfusion dependent. Exclusion of other causes of hemolytic anemias (e. g., infections, toxins, drugs).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

QINLOCK (S)

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): Diagnosis of gastrointestinal stromal tumor (GIST). Disease is advanced. Patient has received prior treatment with three or more kinase inhibitors (e.g., sunitinib, regorafenib), one of which must include imatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

QUALAQUIN (S)

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used solely for the treatment or prevention of nocturnal leg cramps.
Required Medical Information	Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

RAVICTI (S)

Products Affected

- Ravicti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urea cycle disorders (UCDs) (Initial): Both of the following: 1) Diagnosis of UCD AND 2) One of the following deficiencies: a) carbamylphosphate synthetase (CPS), b) ornithine transcarbamylase (OTC), or c) argininosuccinic acid synthetase (AS). Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene. Inadequate response to one of the following: 1) Dietary protein restriction or 2) Amino acid supplementation.
Age Restrictions	N/A
Prescriber Restrictions	UCDs (initial): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
Coverage Duration	UCDs (Initial, reauth): 12 months
Other Criteria	UCDs (reauth): Patient demonstrates positive clinical response to therapy (e.g., plasma ammonia or amino acid levels within normal limits).

RECORLEV (S)

Products Affected

- Recorlev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Cushing's syndrome. Patient is being treated for endogenous hypercortisolemia (e.g., pituitary adenoma, ectopic tumor, adrenal adenoma). One of the following: 1) Patient is not a candidate for surgery, OR 2) Surgery has not been curative. Trial and failure of at least 30 days, or intolerance to oral ketoconazole.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

REGRANEX (S)

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetic neuropathic ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	N/A

REMICADE (S)

Products Affected

- Infliximab

- Remicade

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (Initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Ulcerative colitis (UC) (Initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Rheumatoid arthritis (RA) (Initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (Initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	CD, FCD, UC (initial): Prescribed by or in consultation with a gastroenterologist. RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	Ankylosing spondylitis (AS) (Initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (Initial): Dx of sarcoidosis. TF/C/I to both of the following: one immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine) AND one corticosteroid (eg, prednisone). Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (Reauth): Patient demonstrates positive clinical response to therapy.

REMODULIN (S)

Products Affected

- Treprostinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	Subject to Part B vs. D Review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.

REPATHA (S)

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD (init): One of the following dx: A)HeFH, B)ASCVD, OR C)Primary hyperlipidemia (HLD). One of the following: a) Pt has been receiving the highest tolerable dose of statin therapy, OR b) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR c) Pt has an FDA labeled contraindication to all statins. ONE of the following: 1) One of the following LDL values while on max tolerated lipid lowering tx w/in the last 120 days: a) Patient requires greater than or equal to 25% LDL-C reduction to achieve goal, b) LDL greater than or equal to 55 mg/dL w/ ASCVD, or c) LDL greater than or equal to 70 mg/dL w/o ASCVD. OR 2) Both of the following: a) Patient has been receiving PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe) and b) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering therapy is within normal limits. HoFH (init): Dx of HoFH as confirmed by one of the following: 1)Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2)either untreated/pre-treatment LDL greater than 400 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents. One of the following: 1)Pt is receiving other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe).
Age Restrictions	(Initial) HeFH/HoFH: 10 years or older.
Prescriber Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) at max tolerated dose (unless pt has documented inability to take these medications). HoFH (reauth): One of the following: 1)Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.

RETEVMO (s)

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer: Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medullary Thyroid Cancer (MTC): Diagnosis of medullary thyroid cancer (MTC). Disease is advanced or metastatic. Disease has presence of RET gene mutation tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate. Solid Tumors: Diagnosis of solid tumors. Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s). ONE of the following: a) Disease has progressed on or following prior systemic treatment (e.g., chemotherapy), OR b) There are no satisfactory alternative treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Non-Small Cell Lung Cancer, MTC, Thyroid Cancer, Solid Tumors: 12 months

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	Approve for continuation of prior therapy.
-----------------------	--

REVATIO (S)

Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

REVATIO INJECTION (S)

Products Affected

- Sildenafil INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Patient is unable to take oral medications.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

REVCovi (S)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

REVLIMID (S)

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Myelodysplastic syndromes (MDS): Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q. Mantle cell lymphoma (MCL): Diagnosis of MCL. Follicular Lymphoma (FL): Diagnosis of FL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

REVUFORJ (S)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute leukemia. Disease is relapsed or refractory. Presence of lysine methyltransferase 2A gene (KMT2A) translocation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

REZLIDHIA (S)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

REZUROCK (S)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate].
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	cGVHD (initial): Prescribed by or in consultation with one of the following: hematologist, oncologist, or physician experienced in the management of transplant patients.
Coverage Duration	cGVHD (initial, reauth): 12 months
Other Criteria	cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy.

RINVOQ (S)

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA)(init): Diagnosis (Dx) of moderately to severely active RA. RA,PJIA(init): Minimum (min) duration of a 3-mo(RA)/6-wk(PJIA) trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, (RA only) sulfasalazine. Psoriatic arthritis (PsA)(init): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS)(init): Dx of active AS. Non-radiographic axial spondyloarthritis(NRAS, init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one TNF inhibitors (eg, certolizumab pegol). AS, NRAS(init): Min duration of a 1-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PJIA, PsA, AS(init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PJIA, PsA, AS, NRAS(init, reauth): Not used in combo with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). Atopic dermatitis(AD)(init): Dx of moderate to severe AD. One of the following: Involvement of at least 10% body surface area (BSA), or SCORing Atopic Dermatitis (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for topical corticosteroids), C/I to one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus, Tacrolimus oint, or Eucrisa. One of the following: 1) TF of a min 12-wk supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent), OR 2) Pt has a C/I, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent. Not used in combo with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	AD (initial): Patient is 12 years of age or older

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	RA, PJIA, AS, NRAS, GCA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. CD, UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA, PJIA, PsA, AS, NRAS, CD, UC, AD, GCA (init): 6 months, (reauth): 12 months.

Other Criteria	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. Crohn's disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative colitis (UC) (init): Dx of moderately to severely active UC. One of the following: greater than 6 stools/day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine). Giant cell arteritis (GCA) (init): Dx of GCA. TF/C/I to a glucocorticoid (eg, prednisone). GCA (reauth): Pt demonstrates positive clinical response to therapy. GCA (init, reauth): Not used in combo with other JAK-I, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine). CD/UC (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, ESR, CRP]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).
----------------	--

RINVOQ LQ (s)

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Diagnosis of active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. Psoriatic arthritis (PsA) (init): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PJIA, PsA (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). PJIA, PsA (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	PJIA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	PJIA, PsA (init): 6 months, (reauth): 12 months.
Other Criteria	PJIA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

RITUXAN (S)

Products Affected

- Rituxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma(NHL): One of the following: 1) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Used as first-line treatment in combination with chemotherapy, 2) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy. Used as monotherapy for maintenance therapy, 3) Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma. One of the following: a) Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy or, b) Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy, 4) Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma, 5) Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, OR 6) Diagnosis of one of the following previously untreated, advanced stage indications: a) CD-20-positive diffuse large B-cell lymphoma, b) Burkitt lymphoma, c) Burkitt-like lymphoma, or d) mature B-cell acute leukemia. Patient is 6 months of age or older. Used in combination with chemotherapy. Trial and failure or intolerance (TF/I) to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs).
Age Restrictions	N/A
Prescriber Restrictions	ITP, CLL, NHL: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist. PV: Prescribed by or in consultation with a dermatologist

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	All uses except RA, WG, MPA: 12 mos. RA: 1 month. WG, MPA: 3 months only.
Other Criteria	Immune or idiopathic thrombocytopenic purpura (ITP): Diagnosis of ITP. TF/C/I to one of the following: glucocorticoids (e.g., prednisone, methylprednisolone), immune globulins (e.g., IVIG), or splenectomy. Documented platelet count of less than 50×10^9 /L. Chronic Lymphocytic Leukemia (CLL): Diagnosis of CLL. Used in combination with fludarabine and cyclophosphamide. TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV. Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab) and TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Wegener's Granulomatosis (WG)/Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). All uses: Approve for continuation of prior therapy.

ROMVIMZA (S)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of tenosynovial giant cell tumor (TGCT). Patient is symptomatic. Surgical resection will potentially cause worsening functional limitation or severe morbidity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ROZLYTREK (S)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer (NSCLC). Presence of ROS1 rearrangement positive tumor(s). Solid Tumors: Diagnosis of solid tumors. Presence of neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). No known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: disease has progressed following previous treatment (e.g., surgery, radiation therapy, or systemic therapy) or disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

RUBRACA (S)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Prostate cancer: Diagnosis of castration-resistant prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

RUCONEST (S)

Products Affected

- Ruconest

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

RYBELSUS (S)

Products Affected

- Rybelsus TABS 14MG, 3MG, 7MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

RYDAPT (S)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SABRIL (S)

Products Affected

- Vigabatrin
- Vigadrone
- Vigpoder

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	IS: 1 month to 2 years of age. CPS: 2 years or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SANDOSTATIN (S)

Products Affected

- Octreotide Acetate INJ
1000MCG/ML, 100MCG/ML,
200MCG/ML, 500MCG/ML,
50MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection and/or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Trial and failure, contraindication or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy. Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.

SANDOSTATIN LAR (S)

Products Affected

- Octreotide Acetate INJ 10MG, 20MG, 30MG

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection and/or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Trial and failure, contraindication or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea. Patient had a trial of short-acting octreotide and responded to and tolerated therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy. Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.

SCSEMBLIX (S)

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Disease is Philadelphia chromosome-positive (Ph+). Disease is in chronic phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SCIG (S)

Products Affected

- Cuvitru
- Hizentra
- Hyqvia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Medication is being used subcutaneously. Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) OR one of the following FDA-approved or literature supported diagnoses: 1) Common variable immunodeficiency (CVID), OR 2) Congenital agammaglobulinemia (X-linked or autosomal recessive), OR 3) Severe combined immunodeficiencies (SCID), OR 4) Wiskott-Aldrich syndrome, OR 5) Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine).
Age Restrictions	Primary immunodeficiency (Hyqvia only) (initial): Patient is 2 years of age or older.
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on SCIG therapy (e.g., immunologist, hematologist, neurologist).
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. All uses (reauth): Patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

SEROSTIM (S)

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m ² , or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m ² , or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m ² . Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). Patient has tried and had an inadequate response or intolerance to dronabinol or megestrol acetate.
Age Restrictions	N/A
Prescriber Restrictions	Initial/Reauth: Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial: 3 months. Reauth: 6 months
Other Criteria	HIV wasting (reauth): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI. Patient is currently receiving treatment with antiretrovirals.

SIGNIFOR (S)

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's disease (initial, reauth): 12 months
Other Criteria	Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).

SIGNIFOR LAR (S)

Products Affected

- Signifor Lar INJ 20MG, 40MG, 60MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: a) Inadequate response to surgery or b) Patient is not a candidate for surgery. Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy (e.g., patient's growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved). Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).

SIMPONI ARIA (S)

Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), or b) attestation demonstrating a trial may be inappropriate, OR c) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), one formulary ustekinumab product, Rinvoq/LQ (upadacitinib), Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	All Indications (Initial): 6 months, (Reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.

SKYCLARYS (S)

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Friedreich's ataxia confirmed via genetic testing demonstrating mutation in the FXN gene. Patient has a B-type natriuretic peptide value less than or equal to 200 pg/mL.
Age Restrictions	Initial: Patient is 16 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Physiatrist (Physical Medicine and Rehabilitation Specialist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

SKYRIZI (S)

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML

- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months

Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	---

SOLIRIS (S)

Products Affected

- Soliris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH. Trial and failure, contraindication, or intolerance (TF/C/I) to Ultomiris (ravulizumab). Atypical Hemolytic Uremic Syndrome (aHUS) (initial): Diagnosis of aHUS. TF/C/I to Ultomiris (ravulizumab). Generalized Myasthenia Gravis (gMG) (initial): Diagnosis of gMG. Patient is anti-acetylcholine (AChR) antibody positive. One of the following: A) For patients between 6 and 17 years of age, TF/C/I to one of the following: immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), chronic plasmapheresis/plasma exchange (PE), or intravenous immunoglobulin (IVIG), OR B) For patients 18 years of age or older, one of the following: 1) TF/C/I to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and TF/C/I to chronic plasmapheresis/plasma exchange (PE) or intravenous immunoglobulin (IVIG). Trial and failure, contraindication (e.g., age), or intolerance to Ultomiris (ravulizumab). Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive. One of the following: 1) TF/C/I to Ultomiris (ravulizumab) or 2) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PNH (initial): Prescribed by or in consultation with a hematologist/oncologist. aHUS (initial): Prescribed by or in consultation with a hematologist or nephrologist. NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist. gMG (initial): Prescribed by or in consultation with a neurologist.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	All uses (initial, reauth): 12 months.
Other Criteria	PNH (reauth): Patient demonstrates positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy. aHUS (reauth): Patient demonstrates positive clinical response (e.g., increase in mean platelet counts, hematologic normalization) to therapy. gMG, NMOSD (reauth): Patient demonstrates positive clinical response to therapy.

SOMATULINE DEPOT (S)

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly: Diagnosis of acromegaly. One of the following: A) Inadequate response to one of the following: surgery or radiotherapy, OR B) Not a candidate for one of the following: surgery or radiotherapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (120mg/0.5mL strength only): Diagnosis of GEP-NETs. Disease is one of the following: (a) unresectable, locally advanced or (b) metastatic. Carcinoid syndrome (120mg/0.5mL strength only): Diagnosis of carcinoid syndrome. Used to reduce the frequency of short-acting somatostatin analog rescue therapy.
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist. Carcinoid syndrome (initial): Prescribed by or in consultation with an endocrinologist or oncologist.
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

SOMAVERT (S)

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) failure to one of the following: surgery, radiation therapy, or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) or 2) not a candidate for one of the following: surgery, radiation therapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy. One of the following: 1) inadequate response, contraindication, or intolerance to a somatostatin analog (e.g., octreotide, lanreotide) or 2) clinical rationale provided for preferred treatment with pegvisomant (e.g., comorbid diabetes mellitus is present with acromegaly).
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial and reauth: 12 months
Other Criteria	Acromegaly (reauth): Patient has experienced a positive clinical response to therapy (biochemical control, decrease or normalization of IGF-1 levels).

SPEVIGO (S)

Products Affected

- Spevigo INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized pustular psoriasis (GPP) as defined by primary, sterile, macroscopically visible pustules (excluding cases where pustulation is restricted to psoriatic plaques). Subcutaneous formulation will not be used to treat GPP flare. Patient weighs at least 40kg.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

SPRYCEL (S)

Products Affected

- Dasatinib
- Sprycel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Philadelphia chromosome positive (Ph+)/BCR ABL chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML. Ph+/BCR ABL acute lymphoblastic leukemia (ALL): Diagnosis of Ph+/BCR ABL ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.

STIVARGA (S)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Gastrointestinal stromal tumor (GIST): Diagnosis of locally advanced, unresectable or metastatic GIST. Hepatocellular Carcinoma (HCC): Diagnosis of HCC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

STRENSIQ (S)

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypophosphatasia (initial): Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia. One of the following: 1) Both of the following: a) Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range AND b) Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level]) OR 2) Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing. For patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg.
Age Restrictions	N/A
Prescriber Restrictions	Hypophosphatasia (initial, reauth): Prescribed by a specialist experienced in the treatment of inborn errors of metabolism or an endocrinologist
Coverage Duration	Hypophosphatasia (initial): 6 months, (reauth): 12 months
Other Criteria	Hypophosphatasia (reauth): Patient demonstrates positive clinical response to therapy. For patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg.

SUCRAID (S)

Products Affected

- Sucraid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Congenital Sucrase-Isomaltase Deficiency (CSID) (initial): Diagnosis of sucrase deficiency (which is part of congenital sucrose-isomaltase deficiency [CSID]).
Age Restrictions	N/A
Prescriber Restrictions	CSID (initial): Prescribed by or in consultation with a gastroenterologist or geneticist.
Coverage Duration	CSID (initial, reauth): 12 months.
Other Criteria	CSID (reauth): Patient demonstrates positive clinical response to therapy.

SUTENT (S)

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on, or contraindication or intolerance to Gleevec (imatinib). Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease. Adjuvant treatment of renal cell carcinoma: Diagnosis of renal cell carcinoma (RCC). Used as adjuvant therapy. Patient is at high risk of recurrent RCC following nephrectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

SYLVANT (S)

Products Affected

- Sylvant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multicentric Castleman's disease (MCD) (Initial): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MCD (initial, reauth): 6 months
Other Criteria	MCD (reauth): Patient demonstrates positive clinical response to therapy. Patient is HIV negative and HHV-8 negative.

SYMDEKO (S)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cystic fibrosis. One of the following: 1) Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR 2) Patient has at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	Initial: Patient is 6 years of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations).

SYMLIN (S)

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes. Patient has failed to achieve desired glucose control despite optimal insulin therapy. Patient is taking concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline. Patient is receiving concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).

SYPRINE (S)

Products Affected

- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy

TABRECTA (S)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TADLIQ (S)

Products Affected

- Tadliq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

TAFAMIDIS (S)

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Patient has a transthyretin (TTR) mutation (e.g., V122I), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) Both of the following: i) echocardiogram or cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis, and ii) absence of light-chain amyloidosis. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure.
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): 12 months
Other Criteria	ATTR-CM (reauth): Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure.

TAFINLAR (S)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR both of the following: cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and medication is used in combination with Mekinist (trametinib). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic anaplastic thyroid cancer. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Mekinist (trametinib) .
Age Restrictions	N/A
Prescriber Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib). Low-grade Glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib).

TAGRISSO (S)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): One of the following: A) All of the following: Diagnosis of metastatic NSCLC. One of the following: 1) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), OR 2) Both of the following: a) Patient has known active EGFR T790M mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and b) Patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), or Vizimpro (dacomitinib). OR B) All of the following: Diagnosis of NSCLC. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: 1) Patient is receiving as adjuvant therapy, and 2) Patient has had a complete surgical resection of the primary NSCLC tumor. OR C) All of the following: Diagnosis of NSCLC. Disease is locally advanced. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. FDA-approved test or a test performed at a facility approved by CLIA. Used in combination with both of the following: a) Pemetrexed, and b) Platinum-based chemotherapy (e.g., cisplatin, carboplatin). Or D) Refer to Other Criteria element for additional indication and criteria.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	NSCLC cont: OR D) All of the following: Diagnosis of NSCLC. Disease is one of the following: 1) Locally advanced, or 2) Unresectable (Stage III). Presence of known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy. All indications: Approve for continuation of prior therapy.

TALZENNA (S)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer (mCRPC). Disease is homologous recombination repair (HRR) gene-mutated. Taken in combination with Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TARCEVA (S)

Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND erlotinib will be used in combination with gemcitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

TARGRETIN (S)

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, brentuximab vedotin, methotrexate]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TASIGNA (S)

Products Affected

- Nilotinib Hydrochloride

- Tasigna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TAVNEOS (S)

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of one of the following types of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: a) Granulomatosis with polyangiitis (GPA) OR b) Microscopic polyangiitis (MPA). Diagnosis is confirmed by one of the following: a) ANCA test positive for proteinase 3 (PR3) antigen, b) ANCA test positive for myeloperoxidase (MPO) antigen, OR c) Tissue biopsy. Patient is receiving concurrent immunosuppressant therapy with one of the following: a) cyclophosphamide OR b) rituximab. One of the following: a) Patient is concurrently on glucocorticoids (e.g., prednisone) OR b) History of contraindication or intolerance to glucocorticoids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient does not show evidence of progressive disease while on therapy. Patient is receiving concurrent immunosuppressant therapy (e.g., azathioprine, cyclophosphamide, methotrexate, rituximab).

TAZVERIK (S)

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelioid sarcoma: Diagnosis of epithelioid sarcoma. Disease is one of the following: metastatic or locally advanced. Patient is not eligible for complete resection. Follicular lymphoma: Diagnosis of follicular lymphoma. Disease is one of the following: relapsed or refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TECENTRIQ (S)

Products Affected

- Tecentriq INJ 1200MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	Approve for continuation of prior therapy.

TECFIDERA (S)

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

TEGSEDI (S)

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Patient has a transthyretin (TTR) mutation (e.g., V30M). One of the following: 1) Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, 2) Patient has baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, OR 3) Patient has a baseline neuropathy impairment score (NIS) between 10 and 130. Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy).
Age Restrictions	N/A
Prescriber Restrictions	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	hATTR amyloidosis (initial, reauth): 12 months
Other Criteria	hATTR amyloidosis (reauth): Patient demonstrates postive clinical response to therapy.

TEPMETKO (S)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TERIPARATIDE (S)

Products Affected

- Teriparatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis or osteopenia or men with primary or hypogonadal osteoporosis or osteopenia (initial): Diagnosis of one of the following: a) postmenopausal osteoporosis or osteopenia or b) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Glucocorticoid-Induced Osteoporosis: See Other Criteria section.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial): 24 months. All uses (reauth): 12 months.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	Glucocorticoid-Induced Osteoporosis (initial): Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months. One of the following: 1) BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site), or 2) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, 3) History of one of the following fractures resulting from minimal trauma: vertebral compression fx, fx of the hip, fx of the distal radius, fx of the pelvis, or fx of the proximal humerus, or 4) One of the following: a) glucocorticoid dosing of at least 30 mg per day, or b) cumulative glucocorticoid dosing of at least 5 grams per year. TF/C/I to one bisphosphonate (e.g., alendronate). All uses (initial, reauth): One of the following: 1) Treatment duration of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient's lifetime, or 2) Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)].
-----------------------	--

TESTOSTERONE (S)

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone GEL 20.25MG/1.25GM, 25MG/2.5GM, 40.5MG/2.5GM, 50MG/5GM
- Testosterone Cypionate INJ 100MG/ML, 200MG/ML
- Testosterone Pump

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	Testosterone cypionate only: HG (init): 12 years of age or older. All other testosterone: HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.

TESTOSTERONE ENANTHATE (S)

Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GD: 12 mo. DP: 6 mo.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-----------------------	--

THALOMID (S)

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TIBSOVO (S)

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Newly-Diagnosed AML: Diagnosis of newly-diagnosed AML. One of the following: 1) patient is greater than or equal to 75 years old OR 2) patient has comorbidities that preclude use of intensive induction chemotherapy. Locally Advanced or Metastatic Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is locally advanced or metastatic. Patient has been previously treated. Relapsed or Refractory Myelodysplastic Syndromes: Diagnosis of myelodysplastic syndromes (MDS). Disease is relapsed or refractory. All indications: Patient has an isocitrate dehydrogenase-1 (IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TOPICAL RETINOID (S)

Products Affected

- Avita
- Tretinoin CREA
- Tretinoin GEL 0.01%, 0.025%
- Tretinoin Microsphere GEL 0.04%, 0.1%
- Tretinoin Microsphere Pump GEL 0.1%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TORPENZ (S)

Products Affected

- Torpenz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast Cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

TRACLEER (S)

Products Affected

- Bosentan
- Tracleer TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

TRELSTAR (S)

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TRULICITY (S)

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

TRUQAP (S)

Products Affected

- Truqap TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TRUSELTIQ (S)

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cholangiocarcinoma. Disease is one of the following: a) unresectable locally advanced or b) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has been previously treated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TRYNGOLZA (S)

Products Affected

- Tryngolza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia). One of the following: a) Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1), or b) A North American FCS (NAFCS) Score of greater than or equal to 45. Both of the following: a) One of the following: i) Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate), or ii) Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate), and b) Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or lipid specialist (lipidologist).
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline).

TUKYSA (S)

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) advanced unresectable or b) metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Used in combination with trastuzumab and capecitabine. Patient has received one or more prior anti-HER2 based regimens (e.g., trastuzumab, pertuzumab, ado-trastuzumab emtansine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TURALIO (S)

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tenosynovial Giant Cell Tumor (TGCT): Diagnosis of TGCT. Patient is symptomatic. Patient is not a candidate for surgery due to worsening functional limitation or severe morbidity with surgical removal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TYKERB (S)

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic or recurrent breast cancer. Used in combination with one of the following: Trastuzumab, Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TYMLOS (S)

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: 1) postmenopausal osteoporosis or osteopenia, OR 2) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) For diagnosis of osteoporosis, both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) For diagnosis of osteopenia, both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (max 24 months of therapy per lifetime)

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	N/A
-----------------------	-----

TYSABRI (S)

Products Affected

- Tysabri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance (TF/C/I) to one disease-modifying therapy for MS (e.g., Gilenya [fingolimod], Avonex [Interferon beta-1a], Betaseron [Interferon beta-1b]), 2) Patient is not a candidate for any of the drugs listed as prerequisites due to the severity of their MS, or 3) for continuation of prior therapy. MS (init, reauth): Not used in combination with another disease-modifying therapy for MS. Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), 6-mercaptopurine, azathioprine, methotrexate. TF/C/I to a TNF-inhibitor (eg, adalimumab). CD (initial and reauth): Not used in combination with TNF inhibitors (e.g., adalimumab) or immunosuppressants (eg, 6-MP, azathioprine, cyclosporine, or methotrexate).
Age Restrictions	N/A
Prescriber Restrictions	MS (init, reauth): Prescribed by or in consultation with a neurologist. CD (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (init, reauth): 12mo. CD (Init): 3 mo. CD (Reauth): 12 mo.
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression). CD (reauth): Patient demonstrates positive clinical response (eg, improved disease activity index) to therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

UBRELVY (S)

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy. Will not be used for preventive treatment of migraine. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.

UNITUXIN (S)

Products Affected

- Unituxin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

UPTRAVI (S)

Products Affected

- Uptravi TABS
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

VALCHLOR (S)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy (e.g., topical corticosteroids [e.g., clobetasol, fluocinonide], bexarotene topical gel [Targretin topical gel], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VANFLYTA (S)

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Patient has a FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (FLT3-ITD) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: a) Used in combination with standard cytarabine and anthracycline (e.g., daunorubicin, idarubicin) induction and cytarabine consolidation, and b) Used as maintenance monotherapy following consolidation chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VARIZIG (S)

Products Affected

- Varizig INJ 125UNIT/1.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Presence of contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication).
Required Medical Information	Immune globulin is being used intramuscularly. The immune globulin is being used for passive immunization or post exposure-prophylaxis of varicella. Patient is considered a high risk individual (i.e., immune compromised, pregnant woman, newborn of mother with varicella, premature infant, and infant less than 1 year old).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months (approve one dose only)
Other Criteria	N/A

VELCADE (S)

Products Affected

- Bortezomib INJ 3.5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VENCLEXTA (S)

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Acute Myeloid Leukemia (AML): Diagnosis of newly diagnosed AML. Used in combination with azacitidine, or decitabine, or low-dose cytarabine. One of the following: 1) age 75 years or older OR 2) comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VENTAVIS (S)

Products Affected

- Ventavis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. (Reauth): 12 months
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.

VEOZAH (S)

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe vasomotor symptoms due to menopause. Prescriber attests that baseline serum alanine aminotransferase (ALT), serum aspartate aminotransferase (AST) and total bilirubin levels are less than 2 times the upper limit of normal (ULN) prior to initiating Veozah.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Both of the following within the past 3 months: a) Transaminase elevations are less than 5 times the ULN, and b) Both transaminase elevations are less than 3 times the ULN and the total bilirubin level is less than 2 times the ULN.

VERQUVO (s)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Heart Failure (CHF) (initial): Diagnosis of CHF. Patient has an ejection fraction less than 45 percent. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. One of the following: A) Patient was hospitalized for heart failure within the last 6 months, or B) Patient used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months. Trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), 2) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), or 3) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)], B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone].
Age Restrictions	N/A
Prescriber Restrictions	CHF (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CHF (initial, reauth): 12 months
Other Criteria	CHF (reauth): Patient demonstrates positive clinical response to therapy.

VERZENIO (S)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VICTOZA (S)

Products Affected

- Victoza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). Trial and failure of a minimum 90-day supply or intolerance to two of the following preferred brands: a) Bydureon/Bydureon BCise, b) Byetta, c) Ozempic, d) Trulicity, e) Rybelsus, or f) Mounjaro. Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by one of the following: FibroScan-aspartate aminotransferase (FAST), MRI-aspartate aminotransferase (MAST), or liver biopsy. Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: FibroScan, Fibrosis-4 index (FIB-4), or Magnetic Resonance Elastography (MRE).
Age Restrictions	N/A
Prescriber Restrictions	MASH (Initial): Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	12 months

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates positive response to therapy.
-----------------------	---

VIGAFYDE (S)

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial and failure, or intolerance to generic vigabatrin.
Age Restrictions	Patient is 1 month to 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VIMIZIM (S)

Products Affected

- Vimizim

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis (initial): Diagnosis of Mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome) confirmed by both of the following: a) documented clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.) and b) documented reduced fibroblast or leukocyte GALNS enzyme activity or molecular genetic testing for mutations in the GALNS gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

VITRAKVI (S)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.). Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.). Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]. Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VIZIMPRO (S)

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Disease is positive for one of the following epidermal growth factor receptor (EGFR) mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA): exon 19 deletion or exon 21 L858R substitution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VONJO (S)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Pre-treatment platelet count below $50 \times 10^9/L$.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VORANIGO (S)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of astrocytoma or oligodendroglioma. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VORICONAZOLE INJECTION (S)

Products Affected

- Voriconazole INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i>) or <i>Fusarium</i> spp. including <i>Fusarium solani</i> . For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

VOSEVI (S)

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

VOTRIENT (S)

Products Affected

- Pazopanib Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VOWST (S)

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of two or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Difucid (fidaxomicin), 2) Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days).
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A

VPRIV (S)

Products Affected

- Vpriv

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	Gaucher disease: Patient is 4 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A

VYXEOS (S)

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Newly diagnosed therapy related acute myeloid leukemia (t-AML): Diagnosis of t-AML. Acute myeloid leukemia myelodysplasia-related changes (AML-MRC): Diagnosis of AML-MRC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

WELIREG (S)

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	von Hippel-Lindau (VHL) disease: Diagnosis of VHL disease. Patient requires therapy for one of the following: a) renal cell carcinoma (RCC), b) central nervous system (CNS) hemangioblastoma, or c) pancreatic neuroendocrine tumor (pNET). Patient does not require immediate surgery. Advanced Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma. Disease has progressed after treatment with both of the following: a) One of the following: i) Programmed death receptor-1 (PD-1) inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab)], or ii) Programmed death-ligand 1 (PD-L1) inhibitor [e.g., Bavencio (avelumab), Imfinzi (durvalumab)], and b) Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Votrient (pazopanib), Inlyta (axitinib)]. Pheochromocytoma or Paraganglioma (PPGL): Diagnosis of Pheochromocytoma or Paraganglioma (PPGL). Disease is one of the following: a) locally advanced, b) unresectable, or c) metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

WEZLANA (S)

Products Affected

- Wezlana INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn's disease. Will be used as a maintenance dose following the intravenous induction dose. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose.
Age Restrictions	Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older.
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): 12 months.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	---

WEZLANA IV (S)

Products Affected

- Wezlana INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One time
Other Criteria	Will be administered as an intravenous induction dose. Induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.

XALKORI (S)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of advanced or metastatic NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) or B) Patient has MET amplification- or ROS1 rearrangement-positive tumor as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Anaplastic Large Cell Lymphoma (ALCL): Diagnosis of systemic ALCL. Disease is relapsed or refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Inflammatory Myofibroblastic Tumor (IMT): Diagnosis of IMT. Disease is one of the following: a) unresectable, b) recurrent, or c) refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	IMT, ALCL: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

XATMEP (S)

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL). Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	ALL, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.

XCOPRI (S)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XELJANZ (S)

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Xeljanz tab/Xeljanz XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA/PJIA/PsA/AS (initial): 6 mo, (reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Other Criteria	Xeljanz: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, PJIA (Initial): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. RA, PsA, AS, PJIA (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
------------------------------	---

XENAZINE (S)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication, OR 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Trial and failure, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	N/A
Prescriber Restrictions	HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.
Coverage Duration	All uses: (initial) 3 months. (Reauth) 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

XEOMIN (S)

Products Affected

- Xeomin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. Upper limb spasticity (ULS) (init): Diagnosis of upper limb spasticity. Chronic Sialorrhea (CS) (init): Diagnosis of chronic sialorrhea.
Age Restrictions	ULS, CS (init): Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All indications (init, reauth): 3 months
Other Criteria	CD, blepharospasm, ULS (reauth): Patient demonstrates positive clinical response to therapy. At least 3 months have elapsed or will have elapsed since the last treatment. CS (reauth): Patient demonstrates positive clinical response to therapy. At least 4 months have elapsed or will have elapsed since the last treatment.

XERMELO (S)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Carcinoid syndrome diarrhea (Initial): Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months AND used in combination with SSA therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Carcinoid syndrome diarrhea (Reauthorization): Patient demonstrates positive clinical response to therapy AND drug will continue to be used in combination with SSA therapy.

XGEVA (S)

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) Diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) Diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MM/BMST, GCTB: 12 mo. HCM: 2 mo.
Other Criteria	GCTB: Approve for continuation of prior therapy.

XIFAXAN (S)

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Travelers' diarrhea (TD): Diagnosis of travelers' diarrhea. One of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis (ppx) of hepatic encephalopathy (HE) recurrence (initial): Used for the prophylaxis of hepatic encephalopathy recurrence, AND One of the following: 1) Trial and failure, contraindication or intolerance to lactulose or 2) Add-on treatment to lactulose. Treatment (tx) of HE: Used for the treatment of HE. One of the following: 1) Trial and failure, contraindication, or intolerance to lactulose or 2) Add-on treatment to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TD: 14 days. HE (tx): 12 months. HE (ppx) (init, reauth): 12 months. IBS-D (init, reauth): 2 weeks.
Other Criteria	Prophylaxis of HE recurrence (reauth): Patient demonstrates positive clinical response to therapy. IBS-D (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy.

XOLAIR (S)

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of moderate to severe persistent allergic asthma. Positive skin test or in vitro reactivity to a perennial aeroallergen. One of the following: A) All of the following: a) Patient is 6 years of age or older but less than 12 years of age, b) Pretreatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100-200 mcg fluticasone propionate equivalent/day), and 2) Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR ii) One medium dosed combination ICS/LABA product (eg, Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]), OR B) All of the following: a) Patient is 12 years of age or older, b) Treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day], and 2) Additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR ii) One maximally-dosed combination ICS/LABA product [eg, Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/ formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	IgE-Mediated Food Allergy (init): Patient is 1 year of age or older.

Prescriber Restrictions	Asthma (init/reauth): Prescribed by or in consultation with an allergist/immunologist, or pulmonologist. CSU (init): Prescribed by or in consultation with an allergist/immunologist, or dermatologist. CRSwNP (init/reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. IgE-Mediated Food Allergy (Init/Reauth): Prescribed by or in consultation with an allergist/immunologist.
Coverage Duration	Asthma,init:6mo,reauth:12mo. CSU,init:3mo,reauth:6mo. CRSwNP:12mo. Allergy,init:20wk,reauth:12mo

Other Criteria	Asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with ICS (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]) unless there is a contraindication or intolerance to these medications. Chronic Spontaneous Urticaria (CSU) (init): Diagnosis of CSU. Persistent symptoms (itching and hives) with a second generation H1 antihistamine (eg, cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines. Patient has tried and had an inadequate response or intolerance or contraindication to at least one of the following additional therapies: H2 antagonist (eg, famotidine, cimetidine), leukotriene receptor antagonist (eg, montelukast), H1 antihistamine, hydroxyzine, doxepin. Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. CSU (reauth): Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline. Chronic Rhinosinusitis with Nasal polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for chronic rhinosinusitis with nasal polyps. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for chronic rhinosinusitis with nasal polyps. IgE-Mediated Food Allergy (Initial): One of the following: A) Both of the following: 1) Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following: a) Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food, b) Positive food specific IgE (greater than or equal to 6 kUA/L), c) Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein, AND 2) Clinical history of IgE Mediated Food Allergy, OR B) Provider attestation that patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods. Used in conjunction with food allergen avoidance. Baseline (pre-Xolair tx) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL. Dosing is according to serum total IgE levels and body weight. IgE-Mediated Food Allergy (Reauth): Patient demonstrates positive clinical response to therapy. Used in conjunction with food allergen avoidance. Dosing will continue to be based on body weight and pretreatment total IgE serum levels.
-----------------------	---

XOLREMDI (S)

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Patient has genotype confirmed variant of CXCR4 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells/ μ L.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: immunologist, hematologist, geneticist, dermatologist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

XOSPATA (S)

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Patient has a FMS-like tyrosine kinase (FLT3) mutation as determined by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XPOVIO (S)

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM), Diffuse large B-cell lymphoma (DLBCL): Diagnosis of one of the following: 1) DLBCL OR 2) Multiple Myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XTANDI (S)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic castration-sensitive prostate cancer. Non-metastatic castration-sensitive prostate cancer (nm-CSPC): Diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC). Patient has high-risk biochemical recurrence (BCR) defined by a PSA doubling time less than or equal to 9 months and one of the following: A) PSA values greater than or equal to 1 ng/mL if the patient had prior prostatectomy (with or without radiotherapy) OR B) PSA values at least 2 ng/mL above the nadir if the patient had prior radiotherapy only.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XYREM (S)

Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND One of the following: 1) trial and failure, contraindication (e.g., not indicated for patient's age), or intolerance to one of the following: amphetamine-based stimulant (eg, amphetamine, dextroamphetamine) or methylphenidate-based stimulant, OR 2) age under 18 years old.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.

YERVOY (S)

Products Affected

- Yervoy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

YUFLYMA (S)

Products Affected

- Yuflyma 1-pen Kit
- Yuflyma 2-pen Kit
- Yuflyma 2-syringe Kit
- Yuflyma Cd/uc/hs Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. All Indications (Initial): Trial of two of the following: Humira, brand adalimumab-adbm, or brand adalimumab-aaty.
Age Restrictions	N/A

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

ZALTRAP (S)

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colon and/or rectal cancer: Diagnosis of metastatic colon and/or rectal cancer. Ziv-aflibercept is being used in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI) regimen. Patient has disease that is resistant to or has progressed following an oxaliplatin-containing regimen [e.g., 5-fluorouracil, leucovorin, and oxaliplatin (FOLFOX)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZAVESCA (S)

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease. Niemann-Pick disease type C (NPC) (off-label) (initial): Diagnosis of NPC. Requested drug will be used in combination with Miplyffa (arimoclomol).
Age Restrictions	Gaucher disease: Patient is 18 years of age or older.
Prescriber Restrictions	NPC (initial): Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C.
Coverage Duration	Gaucher disease: 12 months. NPC (initial): 6 months, (reauth): 12 months.
Other Criteria	NPC (reauth): Patient demonstrates positive clinical response to therapy. Requested drug will be used in combination with Miplyffa (arimoclomol).

ZEJULA (S)

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZELBORAF (S)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All indications: Approve for continuation of therapy.

ZOKINVY (S)

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with one of the following: i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m ² and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZOLADEX (S)

Products Affected

- Zoladex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer. Trial and failure, contraindication, or intolerance to Lupron Depot. Endometriosis [Zoladex (3.6 mg strength)]: Treatment of endometriosis. Trial and failure, contraindication, or intolerance to Lupron Depot. Advanced Breast Cancer [Zoladex (3.6 mg strength)]: For the palliative treatment of advanced breast cancer. Endometrial thinning [Zoladex (3.6 mg strength)] For the treatment of dysfunctional uterine bleeding. Used as an endometrial thinning agent prior to endometrial ablation.
Age Restrictions	Endometriosis: 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZOLINZA (S)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or contraindication or intolerance to two systemic therapies (e.g., bexarotene, romidepsin, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZORBTIVE (S)

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS): Diagnosis of SBS. Patient is currently receiving specialized nutritional support (eg, intravenous parenteral nutrition, fluid, and micronutrient supplements). Patient has not previously received 4 weeks of treatment with Zorbtive (somatropin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS: 4 weeks.
Other Criteria	N/A

ZTALMY (S)

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene. Trial and failure, contraindication, or intolerance to two formulary anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine).
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZURZUVAE (S)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): One of the following: A) Diagnosis of severe PPD or B) Both of the following: a) Diagnosis of mild to moderate PPD, and b) Trial and failure, contraindication, or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine). Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	PPD: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy.

ZYDELIG (S)

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Used in combination with Rituxan (rituximab). The patient has relapsed on at least one prior therapy (eg, purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]). Patient is a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZYKADIA (S)

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC that is metastatic or recurrent. Disease is confirmed by presence of an anaplastic lymphoma kinase (ALK)-positive tumor as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZYTIGA (PREFERRED) (S)

Products Affected

- Abiraterone Acetate
- Abirtega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-Resistant Prostate Cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Castration-Sensitive Prostate Cancer (CSPC): Diagnosis of castration-sensitive prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, CSPC: 12 months
Other Criteria	Approve for continuation of prior therapy

PART B VERSUS PART D

Products Affected

- Abecet
- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 50MG
- Akynzeo CAPS
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Astagraf XL
- Azathioprine INJ
- Azathioprine TABS
- Baclofen INJ 20000MCG/20ML, 40MG/20ML, 500MCG/ML, 50MCG/ML
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cladribine
- Clonidine Hcl INJ
- Clonidine Hydrochloride INJ
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Deferoxamine Mesylate
- Dobutamine Hcl INJ 250MG/20ML
- Dobutamine Hcl/d5w INJ 5%; 1MG/ML
- Dobutamine Hydrochloride/dextrose 5%
- Dopamine Hydrochloride INJ
- Dopamine Hydrochloride/dextrose
- Dopamine/d5w INJ 5%; 3.2MG/ML
- Doxorubicin Hcl INJ 2MG/ML, 50MG
- Doxorubicin Hydrochloride INJ 10MG, 2MG/ML
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML
- Floxuridine INJ
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Formoterol Fumarate NEBU
- Gablofen
- Ganciclovir INJ 500MG
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepagam B INJ 312UNIT/ML
- Heplisav-b
- Hyperhep B
- Imovax Rabies (h.d.c.v.)
- Infumorph 200
- Infumorph 500
- Intralipid INJ 20GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Lioresal Intrathecal INJ 0.05MG/ML, 10MG/5ML
- Milrinone Lactate INJ 10MG/10ML, 20MG/20ML, 50MG/50ML
- Milrinone Lactate In Dextrose
- Mitigo
- Morphine Sulfate INJ 1MG/ML

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nabi-hb INJ 312UNIT/ML
- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prograf PACK
- Prosol
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ 1MG/ML

Details

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.

Index Of Drugs

A

Abelcet	444
Abiraterone Acetate.....	443
Abirtega	443
Acetylcysteine	444
Actemra	1, 3
Actemra Actpen.....	3
Actemra IV (s).....	1
Actemra Sc (s).....	3
Actimmune	5
Actimmune (s).....	5
Acyclovir Sodium	444
Adalimumab-aaty (s).....	6
Adalimumab-aaty 1-pen Kit.....	6
Adalimumab-aaty 2-pen Kit.....	6
Adalimumab-aaty 2-syringe Kit.....	6
Adalimumab-aaty Cd/uc/hs Starter	6
Adalimumab-adbm.....	8
Adalimumab-adbm (s).....	8
Adalimumab-adbm Crohns/uc/hs Starter	8
Adalimumab-adbm Psoriasis/uveitis Starter	8
Adalimumab-adbm Starter Package For Crohns Disease/uc/hs	8
Adalimumab-adbm Starter Package For Psoriasis/uveitis.....	8
Adcirca (s)	11
Adempas.....	12
Adempas (s).....	12
Adriamycin.....	444
Afinitor (s).....	13
Afinitor Disperz (s)	14
Aimovig.....	15
Aimovig (s)	15
Akeega.....	16
Akeega (s)	16
Akynzeo	444
Albuterol Sulfate	444

Aldurazyme	17
Aldurazyme (s).....	17
Alecensa	18
Alecensa (s).....	18
Aliqopa.....	19
Aliqopa (s)	19
Alosetron Hydrochloride	205
Alpha-1 Proteinase Inhibitor, Non-preferred (s)..	20
Alunbrig	21
Alunbrig (s).....	21
Alyq.....	11
Ambrisentan	199
Amphotericin B.....	444
Amphotericin B Liposome.....	444
Ampyra (s)	22
Androderm	360
Apokyn (s)	23
Apomorphine Hydrochloride	23
Aprepitant	444
Aralast Np	20
Aranesp (s)	24
Aranesp Albumin Free	24
Arcalyst	26
Arcalyst (s).....	26
Arikayce	28
Arikayce (s).....	28
Armodafinil.....	239
Arzerra	29
Arzerra (s)	29
Astagraf XL	444
Aubagio (s).....	30
Augtyro	31
Augtyro (s)	31
Austedo	32
Austedo (s)	32
Avastin	33
Avastin (s).....	33

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Avita	366
Avonex	222
Avonex Pen	222
Ayvakit	34
Ayvakit (s)	34
Azathioprine	444

B

Baclofen	444
Bafiertam	35
Bafiertam (s)	35
Balversa	36
Balversa (s)	36
Bavencio	37
Bavencio (s)	37
Beleodaq	38
Beleodaq (s)	38
Benlysta	39
Benlysta (s)	39
Berinert	40
Berinert (s)	40
Besremi	41
Besremi (s)	41
Betaseron	222
Bexarotene	350
Bivigam	170
Bleomycin Sulfate	444
Blincyto	42
Blincyto (s)	42
Bortezomib	43, 386
Bortezomib (s)	43
Bosentan	368
Bosulif	44
Bosulif (s)	44
Botox	45
Botox (s)	45
Braftovi	47
Braftovi (s)	47
Brimonidine Tartrate	219
Briviact	48
Briviact (s)	48
Bronchitol	49
Bronchitol (s)	49

Brukinsa	50
Brukinsa (s)	50
Budesonide	444
Bydureon Bcise	51
Byetta	51
Byetta Bydureon (s)	51

C

Cablivi	52
Cablivi (s)	52
Cabometyx	53
Cabometyx (s)	53
Calquence	54
Calquence (s)	54
Caplyta	55
Caplyta (s)	55
Caprelsa	56
Caprelsa (s)	56
Cayston	57
Cayston (s)	57
Cerdelga	58
Cerdelga (s)	58
Cerezyme	59
Cerezyme (s)	59
Chenodal	60
Chenodal (s)	60
Cholbam	61
Cholbam (s)	61
Chorionic Gonadotropin	62
Chorionic Gonadotropin (s)	62
Cialis (s)	63
Ciclopirox (s)	64
Ciclopirox Nail Lacquer	64
Cimzia	65
Cimzia (s)	65
Cimzia Starter Kit	65
Cinryze	68
Cinryze (s)	68
Cladribine	444
Clonidine Hcl	444
Clonidine Hydrochloride	444
Cobenfy	69
Cobenfy (s)	69

Cobenfy Starter Pack.....	69	Deferasirox.....	87
Cometriq.....	70	Deferasirox (s)	87
Cometriq (s).....	70	Deferiprone	120
Copiktra.....	71	Deferoxamine Mesylate	444
Copiktra (s).....	71	Demser (s).....	88
Cosentyx.....	72	Diacomit.....	89
Cosentyx (s).....	72	Diacomit (s)	89
Cosentyx Sensoready Pen	72	Dibenzyliline (s).....	90
Cosentyx Unoready	72	Diclofenac Sodium.....	268
Cotellic	74	Dihydroergotamine Mesylate.....	79, 218
Cotellic (s).....	74	Dimethyl Fumarate	355
Cromolyn Sodium	444	Dimethyl Fumarate Starterpack	355
Ctexli	75	Dobutamine Hcl	444
Ctexli (s).....	75	Dobutamine Hcl/d5w	444
Cuvitru.....	318	Dobutamine Hydrochloride/dextrose 5%	444
Cyclophosphamide	444	Dopamine Hydrochloride.....	444
Cyclosporine.....	444	Dopamine Hydrochloride/dextrose	444
Cyclosporine Modified.....	444	Dopamine/d5w	444
Cyltezo	76	Doxorubicin Hcl.....	444
Cyltezo (s)	76	Doxorubicin Hydrochloride	444
Cyltezo Starter Package For Crohns Disease/uc/hs	76	Dronabinol	213
Cyltezo Starter Package For Psoriasis.....	76	Droxidopa	230
Cyltezo Starter Package For Psoriasis/uveitis	76	Dupixent.....	91
Cyramza	78	Dupixent (s)	91
Cyramza (s)	78	E	
Cytarabine	444	Elaprase.....	94
Cytarabine Aqueous	444	Elaprase (s).....	94
D		Eligard.....	95
D.h.e. 45 (s).....	79	Eligard (s).....	95
Dalfampridine Er.....	22	Eltrombopag Olamine	277
Daliresp (s)	80	Empliciti.....	96
Danyelza.....	81	Empliciti (s)	96
Danyelza (s).....	81	Enbrel	97
Danziten	82	Enbrel (s).....	97
Danziten (s)	82	Enbrel Mini	97
Daraprim (s)	83	Enbrel Sureclick.....	97
Darzalex	84	Endari (s).....	99
Darzalex (s)	84	Engerix-b.....	444
Dasatinib.....	332	Enjaymo	100
Daurismo	86	Enjaymo (s).....	100
Daurismo (s).....	86	Entyvio.....	102
		Entyvio (s).....	102

Entyvio Pen	103
Entyvio Sc (s)	103
Envarsus Xr	444
Epclusa Preferred (s)	104
Epidiolex	105
Epidiolex (s)	105
Epoetin Alfa (s)	106
Epogen.....	106
Epoprostenol (s)	108
Epoprostenol Sodium	108
Erbix.....	109
Erbix (s).....	109
Eribulin Mesylate	142
Erivedge	110
Erivedge (s)	110
Erleada.....	111
Erleada (s)	111
Erlotinib Hydrochloride	349
Esbriet (s)	112
Everolimus	13, 14, 444
Evrysdi	113
Evrysdi (s)	113
Exenatide.....	51
Extavia.....	222
Eylea.....	115
Eylea (s).....	115

F

Fabrazyme	116
Fabrazyme (s).....	116
Fasenra	117
Fasenra (s)	117
Fasenra Pen	117
Fentanyl (s).....	119
Fentanyl Citrate	444
Fentanyl Citrate Oral Transmucosal	119
Feriprox.....	120
Feriprox (s).....	120
Fingolimod Hydrochloride.....	131
Fintepla.....	121
Fintepla (s).....	121
Firazyr (s)	122
Firmagon	123

Firmagon (s).....	123
Flebogamma Dif	170
Floxuridine.....	444
Fluorouracil.....	444
Folotyn	124
Folotyn (s).....	124
Formoterol Fumarate	444
Fotivda	125
Fotivda (s)	125
Fruzaqla.....	126
Fruzaqla (s)	126

G

Gablofen.....	444
Gamastan.....	127
Gamastan (s)	127
Gammagard Liquid	170
Gammagard S/d Iga Less Than 1mcg/ml.....	170
Gammaked	170
Gammaplex	170
Gamunex-c.....	170
Ganciclovir.....	444
Gattex.....	128
Gattex (s).....	128
Gavreto.....	129
Gavreto (s)	129
Gazyva	130
Gazyva (s)	130
Gefitinib	164
Gengraf	444
Genotropin	139
Genotropin Miniquick.....	139
Gilenya.....	131
Gilenya (s).....	131
Gilotrif.....	132
Gilotrif (s)	132
Glassia.....	20
Glatiramer Acetate	133
Glatiramer Acetate (s).....	133
Glatopa.....	133
Gleevec (s)	134
Glycopyrrolate	135
Glycopyrrolate Tablet (s).....	135

Glydo.....	200
Gomekli.....	136
Gomekli (s).....	136
Granisetron Hydrochloride.....	444
Growth Hormone, Non-preferred (s)	137
Growth Hormone, Preferred (s)	139

H

Haegarda.....	141
Haegarda (s)	141
Halaven.....	142
Halaven (s)	142
Hepagam B.....	444
Heplisav-b	444
Herceptin	143
Herceptin (s).....	143
Hetlioz (s).....	144
Hizentra	318
Humatrope.....	137
Humira.....	145
Humira (s)	145
Humira Pediatric Crohns Disease Starter Pack .	145
Humira Pen.....	145
Humira Pen-cd/uc/hs Starter	145
Humira Pen-pediatric Uc Starter Pack	145
Humira Pen-ps/uv Starter	145
Hydroxyprogesterone (s).....	148
Hydroxyprogesterone Caproate.....	148
Hyperhep B	444
Hyqvia	318

I

Ibrance.....	149
Ibrance (s).....	149
Icatibant Acetate.....	122
Iclusig.....	150
Iclusig (s).....	150
Idhifa	151
Idhifa (s)	151
Ilaris.....	152
Ilaris (s)	152
Imatinib Mesylate.....	134
Imbruvica	154
Imbruvica (s)	154

Imfinzi.....	155
Imfinzi (s).....	155
Imkeldi	156
Imkeldi (s).....	156
Imovax Rabies (h.d.c.v.)	444
Increlex	157
Increlex (s)	157
Inflectra	158
Inflectra (s).....	158
Infliximab.....	288
Infumorph 200	444
Infumorph 500	444
Ingrezza.....	160
Ingrezza (s).....	160
Inlyta	161
Inlyta (s).....	161
Inqovi	162
Inqovi (s).....	162
Inrebic	163
Inrebic (s).....	163
Intralipid.....	444
Ipratropium Bromide	444
Ipratropium Bromide/albuterol Sulfate.....	444
Iressa (s)	164
Istodax (s).....	165
Itovebi	166
Itovebi (s)	166
Itraconazole.....	167, 168
Itraconazole Capsule (s).....	167
Itraconazole Solution (s)	168
Ivermectin	169
Ivermectin (s).....	169
Ivig (s).....	170
Iwilfin.....	173
Iwilfin (s)	173

J

Jakafi	174
Jakafi (s).....	174
Jaypirca	175
Jaypirca (s)	175
Jevtana.....	176
Jevtana (s)	176

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Juxtapid	177
Juxtapid (s)	177
Jylamvo	178
Jylamvo (s)	178

K

Kadcyla.....	179
Kadcyla (s)	179
Kalbitor.....	180
Kalbitor (s)	180
Kalydeco.....	181
Kalydeco (s)	181
Kanuma	182
Kanuma (s)	182
Kerendia	183
Kerendia (s)	183
Keytruda	185
Keytruda (s).....	185
Kineret.....	186
Kineret (s).....	186
Kisqali	188
Kisqali (s)	188
Kisqali Femara 200 Dose	189
Kisqali Femara 400 Dose	189
Kisqali Femara 600 Dose	189
Kisqali-femara Pack (s).....	189
Korlym (s)	190
Koselugo.....	191
Koselugo (s)	191
Krazati	192
Krazati (s).....	192
Kuvan (s).....	193
Kyprolis.....	194
Kyprolis (s).....	194

L

Lanreotide (s)	195
Lanreotide Acetate	195
Lapatinib Ditosylate	376
Lazcluze	196
Lazcluze (s)	196
Lemtrada.....	197
Lemtrada (s)	197
Lenalidomide.....	298

Lenvima (s)	198
Lenvima 10 Mg Daily Dose.....	198
Lenvima 12mg Daily Dose	198
Lenvima 14 Mg Daily Dose.....	198
Lenvima 18 Mg Daily Dose.....	198
Lenvima 20 Mg Daily Dose.....	198
Lenvima 24 Mg Daily Dose.....	198
Lenvima 4 Mg Daily Dose.....	198
Lenvima 8 Mg Daily Dose.....	198
Letairis (s)	199
Leuprolide Acetate.....	208
Levalbuterol	444
Levalbuterol Hcl	444
Levalbuterol Hydrochloride.....	444
L-glutamine.....	99
Lidocaine.....	200, 201
Lidocaine Hcl.....	200
Lidocaine Hcl Jelly	200
Lidocaine Hydrochloride	200
Lidocaine Hydrochloride Jelly.....	200
Lidocaine Topical (s)	200
Lidocaine/prilocaine	200
Lidoderm (s).....	201
Lioresal Intrathecal	444
Livmarli.....	202
Livmarli (s)	202
Lonsurf.....	203
Lonsurf (s).....	203
Lorbrena.....	204
Lorbrena (s).....	204
Lotronex (s).....	205
Lumakras.....	206
Lumakras (s)	206
Lumizyme	207
Lumizyme (s)	207
Lupron (s).....	208
Lupron Depot (1-month).....	209
Lupron Depot (3-month).....	209
Lupron Depot (4-month).....	209
Lupron Depot (6-month).....	209
Lupron Depot (s).....	209
Lupron Depot Ped (s).....	210
Lupron Depot-ped (1-month).....	210

Formulary ID: 25500, Version: 14, Effective Date: 08/01/2025

Last Updated: 07/01/2025

Lupron Depot-ped (3-month).....	210
Lupron Depot-ped (6-month).....	210
Lynparza.....	211
Lynparza Tablet (s)	211
Lytgobi	212
Lytgobi (s).....	212

M

Marinol (s).....	213
Mavyret	214
Mavyret (s)	214
Mekinist.....	215
Mekinist (s)	215
Mektovi	217
Mektovi (s)	217
Metyrosine.....	88
Mifepristone	190
Miglustat.....	432
Migranal (s).....	218
Milrinone Lactate	444
Milrinone Lactate In Dextrose	444
Mirvaso (s)	219
Mitigo	444
Mitoxantrone Hcl	231
Modafinil.....	279
Morphine Sulfate.....	444
Mounjaro	220
Mounjaro (s).....	220
Ms Interferons (non-preferred) (s)	221
Ms Interferons (preferred) (s).....	222
Myalept.....	223
Myalept (s)	223
Mycophenolate Mofetil.....	445
Mycophenolic Acid Dr.....	445
Mylotarg.....	224
Mylotarg (s).....	224

N

Nabi-hb.....	445
Naglazyme.....	225
Naglazyme (s)	225
Nerlynx.....	226
Nerlynx (s).....	226
Neulasta.....	227

Neulasta (s)	227
Neulasta Onpro Kit	227
Nexavar (s).....	228
Nilotinib Hydrochloride.....	351
Ninlaro	229
Ninlaro (s)	229
Norditropin Flexpro	137
Northera (s)	230
Novantrone (s)	231
Novarel.....	62
Noxafil Suspension (s).....	232
Nplate	233
Nplate (s).....	233
Nubeqa	234
Nubeqa (s).....	234
Nucala	235
Nucala (s).....	235
Nuedexta	237
Nuedexta (s)	237
Nuplazid.....	238
Nuplazid (s).....	238
Nutrilipid.....	445
Nuvigil (s)	239

O

Ocaliva	241
Ocaliva (s).....	241
Octagam	170
Octreotide Acetate	315, 316
Odomzo.....	242
Odomzo (s).....	242
Ofev.....	243
Ofev (s)	243
Ogsiveo	245
Ogsiveo (s).....	245
Ojemda.....	246
Ojemda (s).....	246
Ojjaara.....	247
Ojjaara (s).....	247
Omnitrope	137
Ondansetron Hcl	445
Ondansetron Hydrochloride.....	445
Ondansetron Odt	445

Onpattro.....	248	Pentamidine Isethionate	445
Onpattro (s)	248	Perjeta	269
Onureg.....	249	Perjeta (s)	269
Onureg (s).....	249	Phenoxybenzamine Hydrochloride.....	90
Opdivo.....	250	Piqray (s).....	270
Opdivo (s).....	250	Piqray 200mg Daily Dose.....	270
Opipza	251	Piqray 250mg Daily Dose.....	270
Opipza (s)	251	Piqray 300mg Daily Dose.....	270
Opsumit	252	Pirfenidone.....	112
Opsumit (s).....	252	Plegridy	222
Orencia	253, 255	Plegridy Starter Pack.....	222
Orencia Clickject.....	255	Plenamine.....	445
Orencia IV (s).....	253	Pomalyst.....	271
Orencia Sc (s)	255	Pomalyst (s)	271
Orenitram	257	Portrazza	272
Orenitram (s)	257	Portrazza (s)	272
Orenitram Titration Kit Month 1.....	257	Posaconazole.....	232
Orenitram Titration Kit Month 2.....	257	Posaconazole Dr.....	273
Orenitram Titration Kit Month 3.....	257	Posaconazole Tablet (s)	273
Orgovyx.....	258	Pralatrexate	124
Orgovyx (s)	258	Praluent	274
Orkambi.....	259, 260	Praluent (s)	274
Orkambi (s)	259	Pregnyl	62
Orkambi Granules (s)	260	Pregnyl W/diluent Benzyl Alcohol/nacl	62
Orserdu	261	Prehevbrio	445
Orserdu (s).....	261	Premasol.....	445
Osphena.....	262	Privigen	170
Osphena (s).....	262	Procrit.....	106
Otezla	263	Procysbi.....	276
Otezla (s)	263	Procysbi (s)	276
Oxlumo.....	264	Prograf.....	445
Oxlumo (s).....	264	Promacta	277
Ozempic	265	Promacta (s)	277
Ozempic (s)	265	Prosol	445
P		Provigil (s)	279
Part B Versus Part D	444	Pulmozyme	281
Pazopanib Hydrochloride.....	402	Pulmozyme (s)	281
Pegasys.....	266	Pyrimethamine	83
Pegasys (s).....	266	Pyrukynd	282
Pemazyre	267	Pyrukynd (s).....	282
Pemazyre (s).....	267	Pyrukynd Taper Pack.....	282
Pennsaid (s)	268		

Q

Qinlock	283
Qinlock (s)	283
Qualaquin (s)	284
Quinine Sulfate	284

R

Rabavert	445
Ravicti	285
Ravicti (s)	285
Rebif	221
Rebif Rebidose	221
Rebif Rebidose Titration Pack	221
Rebif Titration Pack	221
Recombivax Hb	445
Recorlev	286
Recorlev (s)	286
Regranex	287
Regranex (s)	287
Remicade	288
Remicade (s)	288
Remodulin (s)	290
Repatha	291
Repatha (s)	291
Repatha Pushtronex System	291
Repatha Sureclick	291
Retevmo	293
Retevmo (s)	293
Revatio (s)	295
Revatio Injection (s)	296
Revcovi	297
Revcovi (s)	297
Revlimid (s)	298
Revuforj	299
Revuforj (s)	299
Rezlidhia	300
Rezlidhia (s)	300
Rezurock	301
Rezurock (s)	301
Rinvoq	302
Rinvoq (s)	302
Rinvoq Lq	305
Rinvoq Lq (s)	305

Rituxan	306
Rituxan (s)	306
Roflumilast	80
Romidepsin	165
Romvimza	308
Romvimza (s)	308
Rozlytrek	309
Rozlytrek (s)	309
Rubraca	310
Rubraca (s)	310
Ruconest	311
Ruconest (s)	311
Rybelsus	312
Rybelsus (s)	312
Rydapt	313
Rydapt (s)	313

S

Sabril (s)	314
Sajazir	122
Sandimmune	445
Sandostatin (s)	315
Sandostatin Lar (s)	316
Sandostatin Lar Depot	316
Sapropterin Dihydrochloride	193
Scemblix	317
Scemblix (s)	317
Scig (s)	318
Serostim	319
Serostim (s)	319
Signifor	320
Signifor (s)	320
Signifor Lar	321
Signifor Lar (s)	321
Sildenafil	296
Sildenafil Citrate	295
Simponi Aria	322
Simponi Aria (s)	322
Sirolimus	445
Skyclarys	324
Skyclarys (s)	324
Skyrizi	325
Skyrizi (s)	325

Skyrizi Pen	325	Tagrisso (s).....	346
Sodium Oxybate.....	427	Talzenna.....	348
Sofosbuvir/velpatasvir.....	104	Talzenna (s).....	348
Soliris	327	Tarceva (s)	349
Soliris (s)	327	Targretin (s)	350
Somatuline Depot.....	329	Tasigna.....	351
Somatuline Depot (s).....	329	Tasigna (s).....	351
Somavert.....	330	Tasimelteon.....	144
Somavert (s)	330	Tavneos	352
Sorafenib	228	Tavneos (s).....	352
Sorafenib Tosylate.....	228	Tazverik	353
Spevigo.....	331	Tazverik (s)	353
Spevigo (s).....	331	Tecentriq	354
Sprycel.....	332	Tecentriq (s)	354
Sprycel (s)	332	Tecfidera (s).....	355
Stivarga.....	333	Tegsedi	356
Stivarga (s)	333	Tegsedi (s).....	356
Strensiq.....	334	Tepmetko	357
Strensiq (s).....	334	Tepmetko (s)	357
Sucraid.....	335	Teriflunomide	30
Sucraid (s)	335	Teriparatide	358
Sunitinib Malate	336	Teriparatide (s).....	358
Sutent (s)	336	Testosterone	360
Sylvant.....	337	Testosterone (s).....	360
Sylvant (s)	337	Testosterone Cypionate.....	360
Symdeko.....	338	Testosterone Enanthate	362
Symdeko (s).....	338	Testosterone Enanthate (s).....	362
Symlin (s)	339	Testosterone Pump.....	360
Symlinpen 120.....	339	Tetrabenazine	415
Symlinpen 60.....	339	Thalomid	364
Syprine (s)	340	Thalomid (s).....	364
T		Tibsovo	365
Tabrecta	341	Tibsovo (s)	365
Tabrecta (s).....	341	Tobramycin.....	445
Tacrolimus.....	445	Topical Retinoid (s)	366
Tadalafil	11, 63	Torpenz	367
Tadliq	342	Torpenz (s).....	367
Tadliq (s)	342	Tracleer	368
Tafamidis (s)	343	Tracleer (s).....	368
Tafinlar	344	Travasol.....	445
Tafinlar (s).....	344	Trelstar (s).....	369
Tagrisso	346	Trelstar Mixject.....	369
		Treprostinil.....	290

Tretinoin	366
Tretinoin Microsphere	366
Tretinoin Microsphere Pump	366
Trientine Hydrochloride	340
Trulicity	370
Trulicity (s)	370
Truqap	371
Truqap (s)	371
Truseltiq	372
Truseltiq (s)	372
Tryngolza	373
Tryngolza (s)	373
Tukysa	374
Tukysa (s)	374
Turalio	375
Turalio (s)	375
Tykerb (s)	376
Tymlos	377
Tymlos (s)	377
Tysabri	379
Tysabri (s)	379

U

Ubrelvy	380
Ubrelvy (s)	380
Unituxin	381
Unituxin (s)	381
Uptravi	382
Uptravi (s)	382
Uptravi Titration Pack	382

V

Valchlor	383
Valchlor (s)	383
Vanflyta	384
Vanflyta (s)	384
Varizig	385
Varizig (s)	385
Velcade (s)	386
Venclexta	387
Venclexta (s)	387
Venclexta Starting Pack	387
Ventavis	388
Ventavis (s)	388

Veozah	389
Veozah (s)	389
Verquvo	390
Verquvo (s)	390
Verzenio	391
Verzenio (s)	391
Victoza	392
Victoza (s)	392
Vigabatrin	314
Vigadrone	314
Vigafyde	394
Vigafyde (s)	394
Vigpoder	314
Vimizim	395
Vimizim (s)	395
Vinblastine Sulfate	445
Vincristine Sulfate	445
Vitrakvi	396
Vitrakvi (s)	396
Vizimpro	397
Vizimpro (s)	397
Vonjo	398
Vonjo (s)	398
Voranigo	399
Voranigo (s)	399
Voriconazole	400
Voriconazole Injection (s)	400
Vosevi	401
Vosevi (s)	401
Votrient (s)	402
Vowst	403
Vowst (s)	403
Vpriv	404
Vpriv (s)	404
Vyndaqel	343
Vyxeos	405
Vyxeos (s)	405

W

Welireg	406
Welireg (s)	406
Wezlana	407, 409
Wezlana (s)	407

Wezlana IV (s)	409
X	
Xalkori.....	410
Xalkori (s)	410
Xatmep	411
Xatmep (s)	411
Xcopri.....	412
Xcopri (s).....	412
Xeljanz	413
Xeljanz (s)	413
Xeljanz Xr	413
Xenazine (s).....	415
Xeomin	416
Xeomin (s).....	416
Xermelo	417
Xermelo (s).....	417
Xgeva	418
Xgeva (s)	418
Xifaxan	419
Xifaxan (s).....	419
Xolair.....	420
Xolair (s)	420
Xolremdi.....	423
Xolremdi (s)	423
Xospata.....	424
Xospata (s).....	424
Xpovio	425
Xpovio (s).....	425
Xpovio 60 Mg Twice Weekly	425
Xpovio 80 Mg Twice Weekly	425
Xtandi	426
Xtandi (s).....	426
Xyrem.....	427
Xyrem (s).....	427

Y	
Yargesa	432
Yervoy.....	428
Yervoy (s)	428
Yuflyma (s)	429
Yuflyma 1-pen Kit	429
Yuflyma 2-pen Kit	429
Yuflyma 2-syringe Kit	429
Yuflyma Cd/uc/hs Starter	429
Z	
Zaltrap	431
Zaltrap (s).....	431
Zavesca (s)	432
Zejula	433
Zejula (s)	433
Zelboraf.....	434
Zelboraf (s).....	434
Zemaira	20
Zokinvy	435
Zokinvy (s).....	435
Zoladex	436
Zoladex (s)	436
Zolinza	437
Zolinza (s)	437
Zorbtive.....	438
Zorbtive (s).....	438
Ztalmy	439
Ztalmy (s).....	439
Zurzuvaе	440
Zurzuvaе (s)	440
Zydelig	441
Zydelig (s).....	441
Zykadia	442
Zykadia (s)	442
Zytiga (preferred) (s).....	443