PA Criteria

Prior Authorization Group	ABILIFY MYCITE
Drug Names	ABILIFY MYCITE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ABIRATERONE
Drug Names	ABIRATERONE ACETATE, ZYTIGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ACITRETIN
Drug Names	ACITRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ADAKVEO
Drug Names	ADAKVEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	16 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AFINITOR
Drug Names	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), lymphangioleiomyomatosis, gastrointestinal stromal tumors, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, and 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AIMOVIG
Drug Names	AIMOVIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial 3 months, Reauthorization Plan Year
Other Criteria	-

Prior Authorization Group	AKLIEF
Drug Names	AKLIEF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALDURAZYME
Drug Names	ALDURAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis I: diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer, brain metastases from ALK-positive non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALIQOPA
Drug Names	ALIQOPA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Refractory (to at least two prior therapies) follicular lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALOSETRON
Drug Names	ALOSETRON HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from NSCLC.
Exclusion Criteria	-
Required Medical Information	For brain metastases from NSCLC: disease is ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ANADROL
Drug Names	ANADROL-50
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cachexia associated with AIDS (HIV-wasting)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	APOKYN
Drug Names	APOKYN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARANESP
Drug Names	ARANESP ALBUMIN FREE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. Cancer patients who are undergoing palliative treatment.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL. Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500 mU/mL.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	16 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For all uses except anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.

Prior Authorization Group	ARAZLO
Drug Names	ARAZLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	-
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in members initiating or continuing urate-lowering therapy (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	-

Prior Authorization Group	ARIKAYCE
Drug Names	ARIKAYCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ATYPICAL ANTIPSYCHOTICS
Drug Names	FANAPT, FANAPT TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AURYXIA
Drug Names	AURYXIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage will be denied if request is for an indication excluded from Part D.

Prior Authorization Group	AUSTEDO
Drug Names	AUSTEDO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AVASTIN
Drug Names	AVASTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	AYVAKIT
Drug Names	AYVAKIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	B VS. D
Drug Names	ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, AKYNZEO, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN II, AMINOSYN-PF 7%, AMPHOTERICIN B, APREPITANT, ARZERRA, ASTAGRAF XL, ATGAM, AZACITIDINE, AZASAN, AZATHIOPRINE, BENDEKA, BROVANA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINISOL SF 15%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DECITABINE, DEPO-MEDROL, DEPO-PROVERA, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXERCALCIFEROL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, DUOPA, ELIGARD, ELITEK, EMEND, ENGERIX-B, ENVARSUS XR, EPIRUBICIN HCL, ERBITUX, ETOPOPHOS, ETOPOSIDE, EVEROLIMUS, FIRMAGON, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRANISETRON HCL, HALAVEN, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROMORPHONE HCL DOSETTE, HYDROMORPHONE HYDROCHLORI, HYDROXYPROGESTERONE CAPRO, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INFUGEM, INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, IXEMPRA KIT, KADCYLA, KHAPZORY, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, MARQIBO, MEDROL, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MILLIPRED, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, ONIVYDE, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PENTAMIDINE ISETHIONATE, PERFOROMIST, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVERT, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, SMOFLIPID, SOLU-MEDROL, SYNDROS, TACROLIMUS, TAXOTERE, TDVAX, TEMSIROLIMUS, TENIVAC, TOPOSAR, TPN ELECTROLYTES, TRAVASOL, TREANDA, TREXALL, TROPHAMINE, VARUBI, VECTIBIX, VINCRISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, YUPELRI, ZOLEDRONIC ACID, ZORTRESS, ZUPLENZ

PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	N/A
Other Criteria	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.

Prior Authorization Group	BALVERSA
Drug Names	BALVERSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BANZEL
Drug Names	BANZEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BELBUCA
Drug Names	BELBUCA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BELEODAQ
Drug Names	BELEODAQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, and primary cutaneous CD30+ T-cell lymphoproliferative disorders: cutaneous anaplastic large cell lymphoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving standard therapy (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) for SLE OR 2) patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BERINERT
Drug Names	BERINERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): patient has hereditary angioedema with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BESPONSA
Drug Names	BESPONSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For relapsed or refractory B-cell precursor acute lymphoblastic leukemia: The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BETASERON
Drug Names	BETASERON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BEXAROTENE
Drug Names	BEXAROTENE, TARGRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSENTAN
Drug Names	BOSENTAN, TRACLEER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
Exclusion Criteria	-
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: 1) Patient received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient has chronic phase CML (includes newly diagnosed) and meets one of the following conditions: a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOTOX
Drug Names	BOTOX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Excessive salivation secondary to advanced Parkinson's disease, hemifacial spasm.
Exclusion Criteria	Cosmetic use.
Required Medical Information	For chronic migraine prophylaxis, initial treatment: patient experiences at least 15 headache days per month, and patient had an inadequate response, intolerance, or a contraindication to a CGRP inhibitor. For chronic migraine prophylaxis, continuation of treatment (after 2 injection cycles): More headache-free days per month since starting therapy. For urinary incontinence in a patient with a neurologic condition (e.g., spinal cord injury, multiple sclerosis) or with overactive bladder: patient had an inadequate response to or is intolerant of an anticholinergic medication.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Chronic migraine, initial tx: 6 months, renewal: Plan Year. Plan Year for all other indications.
Other Criteria	-

Prior Authorization Group	BRAFTOVI
Drug Names	BRAFTOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRIVIACT
Drug Names	BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRUKINSA
Drug Names	BRUKINSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BUPRENORPHINE
Drug Names	BUPRENORPHINE HCL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) The requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	BUPRENORPHINE PATCH
Drug Names	BUPRENORPHINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BYNFEZIA
Drug Names	BYNFEZIA PEN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas.
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For meningiomas: patient has unresectable disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CALCIPOTRIENE
Drug Names	CALCIPOTRIENE, CALCIPOTRIENE/BETAMETHASO, CALCITRENE, ENSTILAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	-
Required Medical Information	For NSCLC: the requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CERDELGA
Drug Names	CERDELGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Type 3 Gaucher disease
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CINQAIR
Drug Names	CINQAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initial therapy for severe asthma: 1) Either a) Patient has baseline blood eosinophil count of at least 400 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid AND b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy for severe asthma: Asthma control has improved on treatment with the requested drug, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): 1) Patient has C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) Patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For HAE in patients with normal C1 inhibitor: 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema or the angioedema was refractory to a trial of an antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLOBAZAM
Drug Names	CLOBAZAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLOMIPRAMINE
Drug Names	CLOMIPRAMINE HCL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Depression, Panic Disorder
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI) , mirtazapine, bupropion
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.

Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell
Exclusion Criteria	-
Required Medical Information	For NSCLC: The requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COPIKTRA
Drug Names	COPIKTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from melanoma
Exclusion Criteria	-
Required Medical Information	For melanoma (including brain metastases): 1) The disease is unresectable or metastatic, 2) The disease is positive for the BRAF V600E or V600K mutation, AND 3) The requested medication will be used in combination with vemurafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CRINONE
Drug Names	CRINONE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Progesterone supplementation during a confirmed pregnancy.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The requested drug is not being prescribed for fertility.

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of corneal cystine crystal accumulation in patients with cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DALFAMPRIDINE
Drug Names	DALFAMPRIDINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple sclerosis new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DAURISMO
Drug Names	DAURISMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DEFERASIROX
Drug Names	DEFERASIROX, JADENU, JADENU SPRINKLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DEMSER
Drug Names	DEMSER, METYROSINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DESVENLAFAXINE
Drug Names	DESVENLAFAXINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DHE NASAL
Drug Names	DIHYDROERGOTAMINE MESYLAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one triptan 5-HT1 receptor agonist
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored

Prior Authorization Group	DIBENZYLINE
Drug Names	PHENOXYBENZAMINE HYDROCHL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	DICLOFENAC SOLN
Drug Names	DICLOFENAC SODIUM, PENNSAID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Treatment with diclofenac topical solution is necessary due to intolerance or a contraindication to one oral nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DOJOLVI
Drug Names	DOJOLVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For long-chain fatty acid oxidation disorders (LC-FAOD), new starts: 1) patient has a diagnosis of carnitine palmitoyltransferase type 2 (CPT2) deficiency, very-long-chain acyl-CoA dehydrogenase (VLCAD) deficiency, long-chain L-3 hydroxyacyl-CoA dehydrogenase (LCHAD) deficiency or trifunctional protein (TFP) deficiency, AND 2) at least two of the following diagnostic criteria are met: a) disease-specific elevation of acylcarnitine (e.g., C16 and/or C18:1 for CPT2 deficiency, C16-OH and/or C18 and other acylcarnitines for LCHAD and TFP deficiency, C14:1 and/or other long-chain acylcarnitines for VLCAD deficiency) on a newborn blood spot or in plasma, b) low enzyme activity in cultured fibroblasts, c) one or more known pathogenic mutations in CPT2, acyl-CoA dehydrogenase very long chain (ACADVL), hydroxyacyl-CoA dehydrogenase trifunctional multienzyme complex subunit alpha (HADHA) or hydroxyacyl-CoA dehydrogenase trifunctional multienzyme complex subunit beta (HADHB) gene. For LC-FAOD, continuation of therapy: 1) patient has a diagnosis of CPT2, VLCAD, LCHAD or TFP deficiency, AND 2) patient is experiencing benefit from therapy (e.g., improvement in muscle symptoms and/or exercise tolerance).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DOPTELET
Drug Names	DOPTELET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia associated with chronic liver disease: Baseline platelet count prior to a scheduled procedure is less than 50,000/mcL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Chronic liver disease: 1 month, Other: Plan Year
Other Criteria	-

Prior Authorization Group	DRIZALMA
Drug Names	DRIZALMA SPRINKLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer pain, chemotherapy-induced neuropathic pain
Exclusion Criteria	-
Required Medical Information	The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)
Age Restrictions	GAD - 7 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EGRIFTA
Drug Names	EGRIFTA SV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use for weight loss.
Required Medical Information	For human immunodeficiency virus (HIV) infected with lipodystrophy: Patient is receiving anti-retroviral therapy. For patients who have received at least 6 months of the requested medication: Patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference or CT scan.
Age Restrictions	-
Prescriber Restrictions	Infectious disease specialist, endocrinologist
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	ELAPRASE
Drug Names	ELAPRASE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of mucopolysaccharidosis II was confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ELELYSO
Drug Names	ELELYSO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EMGALITY
Drug Names	EMGALITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND 2) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 3) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 4) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 1) The requested drug is being prescribed for the treatment of episodic cluster headaches in an adult patient AND 2) The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline OR 3) The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan medication (i.e., 5-HT1 receptor agonist).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial 3 months, Reauthorization Plan Year
Other Criteria	-

Prior Authorization Group	EMSAM
Drug Names	EMSAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), tricyclic or tetracyclic antidepressants OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENBREL
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Severe, refractory hidradenitis suppurativa.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only):1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENDARI
Drug Names	ENDARI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	5 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENTYVIO
Drug Names	ENTYVIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): Patient must have an inadequate response, intolerance, or contraindication to at least one conventional therapy option (e.g., corticosteroids) OR a tumor necrosis factor (TNF) inhibitor indicated for Crohn's disease. For moderately to severely active ulcerative colitis (new starts only): Patient must have an inadequate response, intolerance, or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids) OR a tumor necrosis factor (TNF) inhibitor indicated for ulcerative colitis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EPO
Drug Names	EPOGEN, PROCRIT, RETACRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis (MF), post-polycythemia vera MF, and post-essential thrombocythemia MF. Cancer patients who are undergoing palliative treatment.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). Additional requirements for primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia. 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	16 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL. 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERLEADA
Drug Names	ERLEADA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ESBRIET
Drug Names	ESBRIET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EUCRISA
Drug Names	EUCRISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) If the patient is 2 years of age or older and the requested drug is being prescribed for use on sensitive skin areas (e.g., face, body skin folds, genital area, armpit, or around the eyes), the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the patient is 2 years of age or older and the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	3 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EVENITY
Drug Names	EVENITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis, patient has ONE of the following (1 or 2): 1) History of fragility fractures, OR 2) Pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has any of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), or b) Patient has failed prior treatment with or is intolerant to previous injectable osteoporosis therapy, or c) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months total
Other Criteria	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg per day.

Prior Authorization Group	FABIOR
Drug Names	FABIOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FARYDAK
Drug Names	FARYDAK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FASENRA
Drug Names	FASENRA, FASENRA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma: For initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). For continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FENSOLVI
Drug Names	FENSOLVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, and 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FERRIPROX
Drug Names	DEFERIPRONE, FERRIPROX, FERRIPROX TWICE-A-DAY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FETZIMA
Drug Names	FETZIMA, FETZIMA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FINTEPLA
Drug Names	FINTEPLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FIRAZYR
Drug Names	ICATIBANT ACETATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER a) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR b) Patient has a family history of angioedema or the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FORTEO
Drug Names	FORTEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy (e.g., injectable bisphosphonate or antiresorptive agent) OR c) Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) Patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Partial-onset seizures: 4 years of age or older, PRIMARY generalized tonic-clonic seizures: 12 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GALAFOLD
Drug Names	GALAFOLD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Fabry disease: Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GATTEX
Drug Names	GATTEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short bowel syndrome (SBS) initial therapy: Patient was dependent on parenteral support for at least 12 months. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GAVRETO
Drug Names	GAVRETO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent or advanced rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GILENYA
Drug Names	GILENYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets either of the following: A) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or B) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC, patient has a known sensitizing EGFR mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GLATIRAMER
Drug Names	GLATIRAMER ACETATE, GLATOPA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	First clinical episode of multiple sclerosis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GOCOVRI
Drug Names	GOCOVRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GONADOTROPIN
Drug Names	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL W/DILUENT BENZYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Patient is female.
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GRALISE
Drug Names	GRALISE, GRALISE STARTER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GRASTEK
Drug Names	GRASTEK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	Prescribed as immunotherapy for the treatment of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens.
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, HUMATROPE COMBO PACK, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, OMNITROPE, SAIZEN, SAIZENPREP RECONSTITUTION, ZOMACTON
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

Prior Authorization Group	HAEGARDA
Drug Names	HAEGARDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, either 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	HARVONI
Drug Names	HARVONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	-

Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	HERCEPTIN HYLECTA
Drug Names	HERCEPTIN HYLECTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	HERZUMA
Drug Names	HERZUMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) for initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) if currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	-

Prior Authorization Group	HIGH RISK MEDICATION
Drug Names	CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR, DIGITEK, DIGOX, DIGOXIN, GUANFACINE ER, METHSCOPOLAMINE BROMIDE, SCOPOLAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Prior Authorization Group	HORIZANT
Drug Names	HORIZANT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	HRM-ANTICONVULSANTS
Drug Names	PHENOBARBITAL, PHENOBARBITAL SODIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Prior Authorization Group	HRM-ANTIPARKINSON
Drug Names	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried the non-HRM alternative drug amantadine AND 5) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

Prior Authorization Group	HRM-HYDROXYZINE
Drug Names	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for pruritus, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

Prior Authorization Group	HRM-HYDROXYZINE INJ
Drug Names	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for nausea/vomiting, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

Prior Authorization Group	HRM-HYPNOTICS
Drug Names	ZOLPIDEM TARTRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) The patient has a contraindication to two of the following non-HRM alternative drugs: doxepin (3mg or 6mg) and trazodone AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 3) One non-HRM alternative drug doxepin (3mg or 6mg) or trazodone has been tried AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: doxepin (3mg or 6mg) or trazodone AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group	HRM-PROMETHAZINE
Drug Names	PHENADOZ, PROMETHAZINE HCL, PROMETHAZINE HCL PLAIN, PROMETHAZINE HYDROCHLORID, PROMETHEGAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) The patient has tried one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Prior Authorization Group	HRM-SKELETAL MUSCLE RELAXANTS
Drug Names	CYCLOBENZAPRINE HYDROCHLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Axial spondyloarthritis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	HYPNOTIC BENZODIAZEPINES
Drug Names	TEMAZEPAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM (non-High Risk Medication) alternative drug doxepin (3mg or 6mg) or trazodone has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM (non-High Risk Medication) alternative drug doxepin (3mg or 6mg) or trazodone OR 3) The patient has a contraindication to two non-HRM (non-High Risk Medication) alternative drugs doxepin (3mg or 6mg) and trazodone AND 4)The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Well-differentiated/dedifferentiated liposarcoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Follow-up therapy after hematopoietic stem cell transplant (HSCT) for CML and ALL patients.
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IDHIFA
Drug Names	IDHIFA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IMATINIB
Drug Names	IMATINIB MESYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, melanoma, and AIDS-related Kaposi sarcoma.
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma, c-Kit mutation is positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders.
Exclusion Criteria	-
Required Medical Information	For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: the disease is relapsed or refractory disease. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: 1) disease is refractory or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: 1) disease is progressive or refractory AND 2) the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: 1) the disease is partially responsive, persistent, or progressive AND 2) the requested drug will be used in patients who have received prior chemoimmunotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IMVEXXY
Drug Names	IMVEXXY MAINTENANCE PACK, IMVEXXY STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INBRIJA
Drug Names	INBRIJA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa. 2) Patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy for Parkinson's disease: the patient is experiencing improvement on the requested drug.

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For renewal, patient is experiencing improvement.

Prior Authorization Group	INGREZZA
Drug Names	INGREZZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INLYTA
Drug Names	INLYTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Papillary, Hurthle cell, or follicular thyroid carcinoma.
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INQOVI
Drug Names	INQOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INREBIC
Drug Names	INREBIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INTRAROSA
Drug Names	INTRAROSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IR BEFORE ER
Drug Names	ARYMO ER, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, HYSINGLA ER, KADIAN, METHADONE HCL, METHADONE HCL INTENSOL, MORPHABOND ER, MORPHINE SULFATE ER, NUCYNTA ER, OXYCONTIN, TRAMADOL HCL ER, XTAMPZA ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has severe continuous pain and the patient has received an immediate-release opioid for at least one week
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IRESSA
Drug Names	IRESSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ISOTRETINOIN
Drug Names	AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Refractory acne, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ISTURISA
Drug Names	ISTURISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea capitis, Tinea manuum/Tinea pedis.
Exclusion Criteria	-
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	IVIG
Drug Names	BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For CLL: 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For BMT/HSCT: 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For PRCA: PRCA is secondary to parvovirus B19 infection. For management of immune checkpoint inhibitor-related nervous system adverse events: 1) Patient has experienced a moderate or severe adverse event to a PD-1 or PD-L1 inhibitor, 2) IVIG is requested to manage one or more of the following nervous system adverse event types: pneumonitis, myasthenia gravis, peripheral neuropathy, encephalitis or transverse myelitis, and 3) the offending medication is temporarily being held or has been discontinued.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Low-risk, accelerated phase, or blast phase myelofibrosis
Exclusion Criteria	-
Required Medical Information	For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	JUXTAPID - PENDING CMS REVIEW
Drug Names	JUXTAPID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initiation of therapy to treat homozygous familial hypercholesterolemia: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin or experienced statin-intolerance, fibrate, bile acid sequestrant, ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the Food and Drug Administration (FDA), AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy to treat HoFH: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or LDL receptor adaptor protein/ARH gene locus, OR 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of familial hypercholesterolemia (FH) by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature atherosclerotic cardiovascular disease (ASCVD) [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

Prior Authorization Group	JYNARQUE
Drug Names	JYNARQUE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: The patient has 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. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
Age Restrictions	4 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.

Prior Authorization Group	KANJINTI
Drug Names	KANJINTI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	KETOCONAZOLE
Drug Names	KETOCONAZOLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cushing's syndrome.
Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.
Required Medical Information	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	KEVEYIS
Drug Names	KEVEYIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary HYPOkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hypokalemic periodic paralysis, OR 3) Patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out. For primary HYPERkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hyperkalemic periodic paralysis, OR 3) Patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months. Continuation: 12 months.
Other Criteria	For continuation of therapy, patient is demonstrating a response to therapy with the requested drug as demonstrated by a decrease in the number or severity of attacks.

Prior Authorization Group	KEYTRUDA
Drug Names	KEYTRUDA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, uveal melanoma, esophageal and esophagogastric junction cancers, Ewing's sarcoma, osteosarcoma, testicular cancer, endometrial carcinoma, anal carcinoma, adrenal gland tumors, penile cancer, central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer (NSCLC), Non-Hodgkin's lymphoma, pancreatic adenocarcinoma, hepatobiliary cancers (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KISQALI
Drug Names	KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For breast cancer: The requested drug is used in combination with an aromatase inhibitor, fulvestrant, or tamoxifen.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KORLYM
Drug Names	KORLYM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KUVAN
Drug Names	KUVAN, SAPROPTERIN DIHYDROCHLORI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For phenylketonuria: For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months. All others: Plan Year.
Other Criteria	-

Prior Authorization Group	LENVIMA
Drug Names	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 Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Medullary thyroid carcinoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LETAIRIS
Drug Names	AMBRISENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LEUKINE
Drug Names	LEUKINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), neutropenia in myelodysplastic syndromes (MDS), aplastic anemia, HIV-related neutropenia, stem cell transplantation-related indications.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	LIBTAYO
Drug Names	LIBTAYO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LIDOCAINE PATCHES
Drug Names	LIDOCAINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LONSURF
Drug Names	LONSURF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LORBRENA
Drug Names	LORBRENA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUCEMYRA
Drug Names	LUCEMYRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Pompe disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUPANETA
Drug Names	LUPANETA PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months (equivalent to 1 treatment course), max 12 months total
Other Criteria	-

Prior Authorization Group	LUPRON
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	-
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	-

Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For HER2-negative, recurrent or metastatic breast cancer, patient must have a deleterious or suspected deleterious germline BRCA mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LYRICA CR
Drug Names	LYRICA CR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MAVYRET
Drug Names	MAVYRET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C).
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from melanoma, uveal melanoma.
Exclusion Criteria	-
Required Medical Information	For brain metastasis from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MEKTOVI
Drug Names	MEKTOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MEMANTINE
Drug Names	MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

Prior Authorization Group	METHERGINE
Drug Names	METHERGINE, METHYLERGONOVINE MALEATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	MIGLUSTAT
Drug Names	MIGLUSTAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	MINOCYCLINE
Drug Names	MINOCYCLINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is shift work disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MOZOBIL
Drug Names	MOZOBIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	MULPLETA
Drug Names	MULPLETA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Baseline platelet count prior to a scheduled procedure is less than 50,000/mcL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	MVASI
Drug Names	MVASI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	MYCAPSSA
Drug Names	MYCAPSSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	NAGLAZYME
Drug Names	NAGLAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NATPARA
Drug Names	NATPARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism.
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NERLYNX
Drug Names	NERLYNX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, gastrointestinal stromal tumor, solitary fibrous tumor, and hemangiopericytoma subtypes), medullary thyroid carcinoma, osteosarcoma, chordoma.
Exclusion Criteria	-
Required Medical Information	For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXLETOL
Drug Names	NEXLETOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXLIZET
Drug Names	NEXLIZET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NINLARO
Drug Names	NINLARO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NITYR
Drug Names	NITYR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NORTHERA
Drug Names	NORTHERA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prior to initial therapy for neurogenic orthostatic hypotension (NOH), patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. For both initial and continuation of therapy for NOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-

Prior Authorization Group	NUBEQA
Drug Names	NUBEQA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NUCALA
Drug Names	NUCALA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initial therapy for severe asthma: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy for severe asthma: Asthma control has improved on treatment with the requested drug, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For initial therapy for eosinophilic granulomatosis with polyangiitis (EGPA): Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level greater than 10 percent. For continuation of therapy for EGPA: Patient has a beneficial response to treatment with the requested drug, demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis.
Age Restrictions	Asthma: 6 years of age or older, EGPA: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas.
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For meningiomas: patient has unresectable disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	ODACTRA
Drug Names	ODACTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	Prescribed as immunotherapy for house dust mite induced allergic rhinitis, confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites or skin testing to licensed house dust mite allergen extracts.
Age Restrictions	18 to 65 years of age
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ODOMZO
Drug Names	ODOMZO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OFEV
Drug Names	OFEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OGIVRI
Drug Names	OGIVRI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	OMEGA-3
Drug Names	OMEGA-3-ACID ETHYL ESTERS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has, or did have prior to the start of treatment with a triglyceride lowering drug, a triglyceride level greater than or equal to 500 mg/dL.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ONTRUZANT
Drug Names	ONTRUZANT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	ONUREG
Drug Names	ONUREG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OPSUMIT
Drug Names	OPSUMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORAL-INTRANASAL FENTANYL
Drug Names	FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA, SUBSYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.] AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.]
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORALAIR
Drug Names	ORALAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescribed as immunotherapy for grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product. (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass).
Age Restrictions	-
Prescriber Restrictions	Allergist/Immunologist or in consultation with an Allergist/Immunologist.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORENITRAM
Drug Names	ORENITRAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORFADIN
Drug Names	NITISINONE, ORFADIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORIAHNN
Drug Names	ORIAHNN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months
Other Criteria	The patient has not already received greater than or equal to 24 months of treatment with the requested drug.

Prior Authorization Group	ORILISSA
Drug Names	ORILISSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months
Other Criteria	-

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: the patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.

Prior Authorization Group	OSMOLEX ER
Drug Names	OSMOLEX ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient experienced an inadequate treatment response or intolerance to amantadine immediate release.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OSPHENA
Drug Names	OSPHENA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OXANDROLONE
Drug Names	OXANDROLONE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	Coverage will be denied if request is for an indication excluded from Part D.

Prior Authorization Group	OXBRYTA
Drug Names	OXBRYTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OXICONAZOLE
Drug Names	OXISTAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to generic clotrimazole cream AND generic ketoconazole cream or shampoo.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-

Prior Authorization Group	PALYNZIQ
Drug Names	PALYNZIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS, PEGASYS PROCLICK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis)
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
Other Criteria	-

Prior Authorization Group	PEMAZYRE
Drug Names	PEMAZYRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PERJETA
Drug Names	PERJETA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent HER2-positive breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy: 6 months. Other: Plan Year
Other Criteria	-

Prior Authorization Group	PHENYLBUTYRATE
Drug Names	SODIUM PHENYLBUTYRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PHESGO
Drug Names	PHESGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year
Other Criteria	-

Prior Authorization Group	PIQRAY
Drug Names	PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	POMALYST
Drug Names	POMALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, acquired immunodeficiency syndrome (AIDS)-related Kaposi sarcoma
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	POTELIGEO
Drug Names	POTELIGEO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult T-cell leukemia/lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PRALUENT
Drug Names	PRALUENT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PREGABALIN
Drug Names	PREGABALIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer-related neuropathic pain, cancer treatment related neuropathic pain.
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the management of postherpetic neuralgia, neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain or cancer treatment related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or management of neuropathic pain associated with spinal cord injury.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PROCYSBI
Drug Names	PROCYSBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: 1) Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) Patient has tried and experienced intolerance to prior therapy with Cystagon (cysteamine bitartrate immediate-release).
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
Other Criteria	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL)

Prior Authorization Group	PULMOZYME
Drug Names	PULMOZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	QBREXZA
Drug Names	QBREXZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	QINLOCK
Drug Names	QINLOCK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	QUETIAPINE XR
Drug Names	QUETIAPINE FUMARATE ER
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
Exclusion Criteria	-
Required Medical Information	For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	QUININE SULFATE
Drug Names	QUININE SULFATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	RAGWITEK
Drug Names	RAGWITEK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	Prescribed as immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen.
Age Restrictions	18 to 65 years of age
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RAVICTI
Drug Names	RAVICTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urea cycle disorders (UCD): Diagnosis of urea cycle disorder was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	REGRANEX
Drug Names	REGRANEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	20 weeks
Other Criteria	-

Prior Authorization Group	RELISTOR INJ
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	-

Prior Authorization Group	RELISTOR TAB
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	-

Prior Authorization Group	REMICADE
Drug Names	REMICADE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RENFLEXIS
Drug Names	RENFLEXIS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RETEVMO
Drug Names	RETEVMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
Age Restrictions	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	REVLIMID
Drug Names	REVLIMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, non-Hodgkin's lymphoma with the following subtypes: AIDS-related diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, nongastric/gastric mucosa associated lymphoid tissue (MALT) lymphoma, primary cutaneous B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, follicular T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL).
Exclusion Criteria	-
Required Medical Information	For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RINVOQ
Drug Names	RINVOQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g. tofacitinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	-

Prior Authorization Group	RITUXAN HYCELA
Drug Names	RITUXAN HYCELA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma, Burkitt lymphoma, Castleman's disease (CD), small lymphocytic lymphoma (SLL), gastric MALT lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), post-transplant lymphoproliferative disorder (PTLD), splenic marginal zone lymphoma
Exclusion Criteria	-
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ROZLYTREK
Drug Names	ROZLYTREK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RUBRACA
Drug Names	RUBRACA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RUCONEST
Drug Names	RUCONEST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): the requested drug is being used for the treatment of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RUXIENCE
Drug Names	RUXIENCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	-

Prior Authorization Group	RYDAPT
Drug Names	RYDAPT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory acute myeloid leukemia
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SAMSCA
Drug Names	SAMSCA, TOLVAPTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	30 days
Other Criteria	Therapy with the requested drug was initiated (or re-initiated) in the hospital.

Prior Authorization Group	SARCLISA
Drug Names	SARCLISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SEROSTIM
Drug Names	SEROSTIM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of HIV patients with wasting or cachexia: The requested medication is used in combination with antiretroviral therapy. Patient has had a suboptimal response to at least 1 other therapy for wasting or cachexia (e.g., megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) or patient has contraindication or intolerance to alternative therapies. For continuation of therapy, patient must have demonstrated a response to therapy with the requested medication (i.e., body mass index (BMI) has increased or stabilized).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	-

Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SIGNIFOR LAR
Drug Names	SIGNIFOR LAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) patient has high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery OR there is a clinical reason for why the patient has not had surgery.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	The requested drug is not being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria

Prior Authorization Group	SKYRIZI
Drug Names	SKYRIZI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gastrointestinal stromal tumor (GIST)
Exclusion Criteria	-
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib, or regorafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	STELARA
Drug Names	STELARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) the patient had an inadequate response, intolerance, or contraindication to Humira. For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to Humira or Xeljanz/Xeljanz XR. For moderately to severely active Crohn's disease (new starts only): patient had an inadequate response, intolerance, or contraindication to Humira. For moderately to severely active ulcerative colitis (new starts only): patient had an inadequate response, intolerance, or contraindication to Humira or Xeljanz.
Age Restrictions	Plaque psoriasis: 6 years of age or older. All other indications: 18 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Progressive gastrointestinal stromal tumors (GIST)
Exclusion Criteria	-
Required Medical Information	For colorectal cancer: The disease is unresectable, advanced, or metastatic. The patient has progressed on treatment with EITHER 1) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR 2) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SUNOSI
Drug Names	SUNOSI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy confirmed by sleep lab evaluation AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate) (NOTE: Coverage of amphetamines may require prior authorization) AND 3) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) (NOTE: Coverage of armodafinil may require prior authorization) OR 4) The patient has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) confirmed by polysomnography AND 5) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) (NOTE: Coverage of armodafinil may require prior authorization).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in daytime sleepiness with obstructive sleep apnea (OSA).

Prior Authorization Group	SUTENT
Drug Names	SUTENT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and hemangiopericytoma subtypes), chordoma, thymic carcinoma
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYLATRON
Drug Names	SYLATRON
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.

Prior Authorization Group	SYMLIN
Drug Names	SYMLINPEN 120, SYMLINPEN 60
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYMPAZAN
Drug Names	SYMPAZAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYNRIBO
Drug Names	SYNRIBO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT), treatment of chronic CML patients with a T315I mutation.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TABRECTA
Drug Names	TABRECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Treatment of recurrent or advanced non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TADALAFIL (PAH)
Drug Names	ALYQ, TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma)
Exclusion Criteria	-
Required Medical Information	For brain metastases from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases from non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	For metastatic or recurrent non-small cell lung cancer (NSCLC), patient must have sensitizing EGFR mutation-positive NSCLC (including brain metastases from non-small cell lung cancer).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAKHZYRO
Drug Names	TAKHZYRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE), the requested drug is being used for the prevention of HAE attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TALZENNA
Drug Names	TALZENNA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TARCEVA
Drug Names	ERLOTINIB HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Chordoma, renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For NSCLC (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TASIGNA
Drug Names	TASIGNA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	-
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAZAROTENE
Drug Names	TAZAROTENE, TAZORAC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAZVERIK
Drug Names	TAZVERIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TECENTRIQ
Drug Names	TECENTRIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets one of the following: 1) The requested medication will be used as first line treatment for NSCLC with high programmed death-ligand 1 (PD-L1) expression (PD-L1 stained greater than or equal to 50 percent of tumor cells) with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic aberrations, OR 2) The disease has progressed during or following cytotoxic chemotherapy, OR 3) Patient has positive EGFR mutation, positive ALK, or positive c-ros oncogene 1 (ROS1) gene rearrangement and has had disease progression on targeted FDA-approved therapy (e.g., erlotinib, afatinib, gefitinib, crizotinib, ceritinib) prior to receiving the requested drug, OR 4) Patient has non-squamous histology and has negative EGFR, negative ALK, negative ROS1 non-small cell lung cancer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	TESTOSTERONE CYPIONATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria in transgender male patients
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TESTOSTERONE ENANTHATE INJ
Drug Names	TESTOSTERONE ENANTHATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria in transgender male patients.
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 4) Requested drug is being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 5) Requested drug is being prescribed for delayed puberty in a male patient OR 6) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Chronic tics, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	-
Required Medical Information	For treatment of chorea associated with Huntington's disease and tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	THALOMID
Drug Names	THALOMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, human immunodeficiency virus (HIV)-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	-
Required Medical Information	For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TIBSOVO
Drug Names	TIBSOVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TIGLUTIK
Drug Names	TIGLUTIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Patient has difficulty swallowing oral tablets or capsules.

Prior Authorization Group	TOBI INHALER
Drug Names	TOBI PODHALER
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOBRAMYCIN
Drug Names	BETHKIS, TOBRAMYCIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TOLSURA
Drug Names	TOLSURA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	TOPICAL LIDOCAINE
Drug Names	GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, TESTOSTERONE, TESTOSTERONE PUMP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria in transgender male patients.
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOPICAL TRETINOIN
Drug Names	ALTRENO, AVITA, RETIN-A MICRO, RETIN-A MICRO PUMP, TRETINOIN, TRETINOIN MICROSPHERE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRAZIMERA
Drug Names	TRAZIMERA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TREPROSTINIL INJ
Drug Names	TREPROSTINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TRIENTINE
Drug Names	CLOVIQUE, TRIENTINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRIKAFTA
Drug Names	TRIKAFTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis (CF): The patient has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The requested medication will not be used in combination with other medications containing ivacaftor.

Prior Authorization Group	TRODELVY
Drug Names	TRODELVY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent triple-negative breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRUXIMA
Drug Names	TRUXIMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	-

Prior Authorization Group	TUKYSA
Drug Names	TUKYSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastasis, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TURALIO
Drug Names	TURALIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TYKERB
Drug Names	LAPATINIB DITOSYLATE, TYKERB
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Metastatic CNS lesions from HER2-positive breast cancer, recurrent EGFR-positive chordoma.
Exclusion Criteria	-
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TYMLOS
Drug Names	TYMLOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Prior Authorization Group	TYVASO
Drug Names	TYVASO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VELCADE
Drug Names	BORTEZOMIB, VELCADE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mantle cell lymphoma
Exclusion Criteria	-
Required Medical Information	For AML, patient meets any of the following: 1) the patient is 60 years of age or older, OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse, OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VENTAVIS
Drug Names	VENTAVIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VERZENIO
Drug Names	VERZENIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIBERZI
Drug Names	VIBERZI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIGABATRIN
Drug Names	VIGABATRIN, VIGADRONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIMIZIM
Drug Names	VIMIZIM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of mucopolysaccharidosis IVA disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 6-sulfatase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VITRAKVI
Drug Names	VITRAKVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIZIMPRO
Drug Names	VIZIMPRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VORICONAZOLE
Drug Names	VORICONAZOLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prophylaxis of invasive aspergillosis in a high-risk patient, empiric antifungal therapy for febrile neutropenia in a high-risk patient, pulmonary aspergillosis, oropharyngeal candidiasis, mycosis due to Scedosporium prolificans
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	The patient will be using the requested drug orally or intravenously.

Prior Authorization Group	VOSEVI
Drug Names	VOSEVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VPRIV
Drug Names	VPRIV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VRAYLAR
Drug Names	VRAYLAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VYNDAMAX
Drug Names	VYNDAMAX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of hereditary transthyretin-mediated amyloidosis: Initiation, patient is positive for a mutation of the transthyretin (TTR) gene and exhibits clinical manifestation of disease. Continuation, patient demonstrates a beneficial response to therapy. For cardiomyopathy of wild type transthyretin-mediated amyloidosis: Initiation, patient has transthyretin precursor proteins confirmed by testing and exhibits clinical manifestation of disease. Continuation, patient demonstrates a beneficial response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VYNDAQEL
Drug Names	VYNDAQEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of hereditary transthyretin-mediated amyloidosis: Initiation, patient is positive for a mutation of the transthyretin (TTR) gene and exhibits clinical manifestation of disease. Continuation, patient demonstrates a beneficial response to therapy. For cardiomyopathy of wild type transthyretin-mediated amyloidosis: Initiation, patient has transthyretin precursor proteins confirmed by testing and exhibits clinical manifestation of disease. Continuation, patient demonstrates a beneficial response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XALKORI
Drug Names	XALKORI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, ALK- or ROS1-postive brain metastases from NSCLC, ALK-positive inflammatory myofibroblastic tumors (IMT), ALK-positive anaplastic large cell lymphoma (ALCL).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to MTX or other nonbiologic DMARDs OR a prior biologic DMARD, AND 2) The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., aminosalicylates), or 2) Inadequate response or intolerance to a prior biologic DMARD.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XEOMIN
Drug Names	XEOMIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Cosmetic use.
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XGEVA
Drug Names	XGEVA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic mastocytosis related osteopenia or osteoporosis
Exclusion Criteria	-
Required Medical Information	For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Reduction in risk of overt HE recurrence: 6 Months, IBS-D: 14 Days
Other Criteria	-

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	-

Prior Authorization Group	XOSPATA
Drug Names	XOSPATA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XPOVIO
Drug Names	XPOVIO 100 MG ONCE WEEKLY, XPOVIO 40 MG ONCE WEEKLY, XPOVIO 40 MG TWICE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XTANDI
Drug Names	XTANDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XYREM
Drug Names	XYREM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) wakefulness promoting drug and at least one central nervous system (CNS) stimulant drug OR 3) If the patient is less than 18 years of age, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) stimulant drug (NOTE: Examples of a central nervous system (CNS) stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a central nervous system (CNS) wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines may require prior authorization). OR 4) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy
Age Restrictions	7 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Prior Authorization Group	YERVOY
Drug Names	YERVOY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases with melanoma, small cell lung cancer, non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZARXIO
Drug Names	ZARXIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplant.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	ZEJULA
Drug Names	ZEJULA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases with melanoma, non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), rectal cancer, and colon cancer.
Exclusion Criteria	-
Required Medical Information	For brain metastases with melanoma, all of the following criteria must be met: 1) The tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation), and 2) The requested drug will be used in combination with cobimetinib. For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma, tumor is positive for BRAF mutation. For rectal cancer, tumor is positive for the BRAF V600E mutation. For colon cancer, tumor is positive for the BRAF V600E mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZELNORM
Drug Names	ZELNORM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZIRABEV
Drug Names	ZIRABEV
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZORBTIVE
Drug Names	ZORBTIVE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Gastroenterologist or nutritional support specialist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor, recurrent ALK-positive non-small cell lung cancer (NSCLC), metastatic or recurrent ROS1-positive NSCLC, brain metastases from NSCLC.
Exclusion Criteria	-
Required Medical Information	For NSCLC, patient has recurrent or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor, the tumor is ALK-positive. For brain metastases, patient has ALK-positive NSCLC.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYPREXA RELPREVV
Drug Names	ZYPREXA RELPREVV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-