Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adcirca

Products Affected

- ALYQ
- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

AED Briviact

Products Affected

- *brivaracetam oral solution*
- *brivaracetam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AED Dilantin

Products Affected

- DILANTIN ORAL CAPSULE 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AED Fycompa

Products Affected

- *perampanel oral suspension*
- *perampanel oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AED levETIRAcetam

Products Affected

- *levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg* 750 MG
- SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AED Xcopri

Products Affected

- XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AED Zonegran

Products Affected

- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Eslicarbazepine Acetate, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR/ER, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

AFINITOR

Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- YULITHIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Aimovig

Products Affected

- AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Akeega

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mCRPC, BRCA-mutation status. For mCSPC, BRCA2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual meets one of the following: (A) Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog (e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix) OR (B) Has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alpha1 Proteinase Inhibitor

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Alunbrig

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Amphetamine Salts

Products Affected

- *amphetamine-dextroamphet er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ampyra

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renewal, individual achieved and sustained improvement in ambulation related functional status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Augtyro

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status. For solid tumor, NTRK gene fusion status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Austedo

Products Affected

- AUSTEDO
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Auvelity

Products Affected

- AUVELITY
- AUVELITY TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. For MDD, individual has had a prior trial and inadequate response to ANY ONE generic bupropion agent (Bupropion, bupropion SR, bupropion XL) AND has had a prior trial and inadequate response to ONE generic antidepressant for major depressive disorder (MDD) (i.e. Citalopram, Desvenlafaxine ER, Duloxetine, Escitalopram, Fluoxetine, Fluvoxamine, Mirtazapine, Nefazodone, Paroxetine, Paroxetine CR, Sertraline, Trazodone, Venlafaxine, Venlafaxine ER, Vilazodone).
Age Restrictions	For MDD, Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Avmapki Fakzynja

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Ovarian Cancer, KRAS mutation status. Individual has an Eastern Cooperative Group (ECOG) performance status of 0-1.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ayvakit

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Advanced Systemic Mastocytosis (AdvSM) and Indolent Systemic Mastocytosis (ISM), individual has a platelet count of greater than or equal to 50 x 109/L. For GIST, PDGFRA exon 18 mutation status, including PDGFRA D842V mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Balversa

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mUC, FGFR3 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Banzel

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	Individual is 1 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Besremi

Products Affected

- BESREMI
- BESREMI PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bosulif

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	The individual has one of the following mutations: T315I, V299L, G250E, or F317L.
Required Medical Information	For CML/ALL, Philadelphia Chromosome status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Braftovi

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For melanoma, NSCLC, colon/rectal BRAF V600 status. For colon/rectal dMMR/MSI-H or POLE/POLD1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Brukinsa

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has no history of progression with prior BTK inhibitor usage.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Buphenyl

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Bysanti

Products Affected

- BYSANTI
- BYSANTI TITRATION PACK A
- BYSANTI TITRATION PACK B
- BYSANTI TITRATION PACK C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cabometyx

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Calquence

Products Affected

- CALQUENCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Carbaglu

Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Cayston

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cialis BPH

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of benign prostatic hyperplasia (BPH) and is using to treat the signs and symptoms of BPH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial and inadequate response or intolerance to TWO of the following agents: Alfuzosin, Doxazosin, Silodosin, Tamsulosin, or Terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cometriq

Products Affected

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Copiktra

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Corlanor

Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Cosentyx

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS
- SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For unresectable or metastatic melanoma, Individual is using in combination with Zelboraf (vemurafenib) with or without Tecentriq (atezolizumab).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cresemba

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Cystagon

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is demonstrated by one of the following (Elmonem 2016) (a) Elevated cystine level in white blood cells OR (b) Pathogenic mutation in the CTNS gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Danziten

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML, Ph status, T315I, Y253H, E255K/V, F359V/C/I or G250E status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daraprim

Products Affected

- *pyrimethamine oral*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 75 years old or older OR has comorbidities that preclude use of intensive induction chemotherapy.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DHE Nasal Agents

Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to up to TWO of the following oral agents: Almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan OR If oral triptan agents are not acceptable due to concomitant clinical conditions, such as but not limited to the following: (A) Individual is unable to take oral medications due to one of the following: (1) Individual experiences nausea and vomiting due to migraines OR (2) requires a more rapid onset of action due to short aura time period OR (3) cannot swallow tablets and there are no preferred ODT (oral disintegrating tablet) formulations OR (B) individual is unable to tolerate oral triptan therapy OR (C) Individual has history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, and other vascular risk factors or disorders.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Diacomit

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL PACKET 250 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For dx of seizures associated with Dravet Syndrome AND is taking in combination with clobazam AND has responded inadequately to TWO previous antiepileptic drugs (e.g. valproic acid, topiramate, clobazam) (Wirrell 2017, Ziobro 2018).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Diazepam HRM

Products Affected

- DIAZEPAM INTENSOL
- *diazepam oral concentrate*
- *diazepam oral solution 5 mg/5ml*
- *diazepam oral tablet 10 mg, 2 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis (all ages) and One of the following: (1) if over 65 years of age or older, Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] and the physician has indicated the requested medication is not causing adverse effects. OR (2) has a contraindication or has a clinical reason not to use safer alternatives (ABIM Foundation/AGS 2013). Or (3) individual is 6 months to 64 years of age.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dificid

Products Affected

- *fidaxomicin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Month.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dimethyl Fumarate

Products Affected

- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dupixent

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Duragesic Patch

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Elidel

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as second-line therapy for mild to moderate atopic dermatitis AND has had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid. OR Use of topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2023, Eleftheriadou 2022): (A). Individual has atopic dermatitis, psoriasis, or vitiligo recalcitrant to topical corticosteroids OR (B) Individual has atopic dermatitis lesions, psoriasis, or vitiligo in sensitive areas (such as face, anogenital area or skin folds) OR (C) Individual has steroid-induced atrophy OR (D) Individual has history of long-term or uninterrupted topical steroid use.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ELIGARD_GNRH

Products Affected

- ELIGARD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of Prostate cancer and being used as androgen deprivation therapy as a single agent or in combination with antiandrogen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Emsam

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has no known contraindications to the use of a monoamine oxidase inhibitor (MAOI).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Enbrel

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-

INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Endari

Products Affected

- *l-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Ensacove

Products Affected

- ENSACOVE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Entyvio SQ

Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Epclusa

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For tx of seizures associated with Lennox-Gastaut syndrome or Dravet Syndrome, Individual has responded inadequately to two previous antiepileptic drugs (e.g., valproic acid, topiramate, clobazam) (Hancock 2013. Wirrell 2017. Ziobro 2018). Individual is using for tuberous sclerosis complex.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Epogen and Procrit

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erleada

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR Has had a bilateral orchiectomy. For non-metastatic castration-resistant prostate cancer (nmCRPC), Individual has a PSA doubling time (PSADT) less than or equal to 10 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erwinase

Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has developed confirmed (written or verbal) systemic allergic reaction or anaphylaxis to prior treatment with E. Coli-derived asparaginase OR have silent inactivation [defined as a day 7 asparaginase activity level below 0.1 IU/mL and/or a day 14 level below the lower limit of quantification (LLQ).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Esbriet

Products Affected

- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

External Insulin Pumps

Products Affected

- OMNIPOD 5 DEXG7G6 INTRO GEN 5
- OMNIPOD 5 DEXG7G6 PODS GEN 5
- OMNIPOD 5 LIBRE INTRO
- OMNIPOD 5 LIBRE PODS
- OMNIPOD DASH INTRO (GEN 4)
- OMNIPOD DASH PODS (GEN 4)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has diagnosis of diabetes Mellitus (any type). Individual or the individual's caregiver(s) has completed a comprehensive diabetes education program AND requires insulin injections multiple times daily AND requires multiple blood glucose tests/readings daily.
Age Restrictions	Individual is 2 years of age or older for DM1, or is 18 years of age or older for DM2.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Exxua

Products Affected

- EXXUA
- EXXUA TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fetzima

Products Affected

- FETZIMA
- FETZIMA TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For MDD, individual has had a trial of TWO of the following: Desvenlafaxine, duloxetine, fluoxetine, fluvoxamine, escitalopram, citalopram, paroxetine, sertraline, mirtazapine, nefazodone, trazodone, venlafaxine, vilazodone or bupropion.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Filspari

Products Affected

- FILSPARI ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Fintepla

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss/reduction.
Required Medical Information	Diagnosis: Lennox-Gastaut syndrome (LGS), Dravet Syndrome (DS).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of seizures associated with Lennox-Gastaut syndrome or Dravet Syndrome AND has responded inadequately to two previous antiepileptic drugs (Lagae 2019, Wirrell 2017, Ziobro 2018).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Firazyr

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*
- SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Firmagon

Products Affected

- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of prostate cancer AND is using as androgen deprivation therapy as a single agent or in combination with an antiandrogen OR Individual currently has a cancer diagnosis AND meets one of the following: (a) mbr will receive chemotherapy for cancer with a curative intent OR (b) mbr will receive radiation therapy for cancer with a curative intent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Forteo

Products Affected

- *teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Fotivda

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For RCC, individual has received at least two prior systemic therapies AND at least one prior systemic therapy included a vascular endothelial growth factor receptor tyrosine kinase inhibitor (VEGFR TKI), such as axitinib, cabozantinib, lenvatinib, sunitinib, or pazopanib (Rini 2020).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fruzaqla

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gavreto

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has written or verbal confirmation of RET fusion (or rearrangement) positive tumors. For NSCLC, individual has not received treatment with another RET rearrangement positive-targeted agent, such as cabozantinib, vandetanib, or selpercatinib (NCT03037385).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gilenya

Products Affected

- *fingolimod hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	I. Mbr has had a trial and inadeq resp or intol to one of the following: Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Glatiramer Acetate/Glatopa, Dimethyl Fumarate, or Teriflunomide OR II. Mbr has high dz activity despite tx with a dz modifying drug (including Aubagio, Avonex, Bafiertam, Extavia, Kesimpta, Plegridy, Ponvory Rebif, Betaseron, Briumvi Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Copaxone/Glatiramer/Glatopa, Tecfidera, Tyruko,Tysabri, Vumerity and Zeposia) OR III. Mbr is tx naive (no previous hx of use of disease modifying drugs such as Aubagio, Avonex, Bafiertam, Betaseron, Briumvi, Copaxone/Glatiramer/Glatopa, Extavia, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory Rebif, Tecfidera, Tyruko,Tysabri, Vumerity and Zeposia) AND has rapidly evolving sev relapsing MS OR IV. Mbr is between 10-17 years of age and has a dx of RMS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

H8267_16_4530_0926_C EFFECTIVE DATE 01/01/2027

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Glatiramer Agents

Products Affected

- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml* MG/ML, 40 MG/ML
- GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gleevec

Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*
- *imkeldi*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML/ALL Philadelphia chromosome (Ph) status. For Myelodysplastic/Myeloproliferative disorders, (PDGFR) status. For HES, FIP1L1-PDGFR. For GIST, CD117 status. For ASM, D816V c-kit mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gleostine

Products Affected

- *lomustine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP 1 Mounjaro

Products Affected

- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

GLP 1 Semaglutide

Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG
- RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

H8267_16_4530_0926_C EFFECTIVE DATE 01/01/2027

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

GLP 1 Trulicity

Products Affected

- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

GLP 1 Victoza

Products Affected

- *liraglutide*

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Gomekli

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For neurofibromatosis type 1 (NF1), individual has a Body Surface Area greater than or equal to 0.40 m2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Hepsera

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	12 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial and inadequate response or intolerance to or has a contraindication to an alternative antiviral agent with a higher genetic barrier to resistance for Hepatitis B [such as entecavir or tenofovir] (AASLD 2016).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hernexeos

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, HER2 (ERBB2) tyrosine kinase mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hetlioz

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

HRM Age Amitriptyline

Products Affected

- *amitriptyline hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Amoxapine

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Benztropin

Products Affected

- *benztropine mesylate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Cyclobenzaprine

Products Affected

- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Dicyclomine

Products Affected

- *dicyclomine hcl oral capsule*
- *dicyclomine hcl oral solution 10 mg/5ml*
- *dicyclomine hcl oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Guanfacine

Products Affected

- *guanfacine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Hydroxyzine

Products Affected

- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Meclizine

Products Affected

- *meclizine hcl oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Promethazine

Products Affected

- *promethazine hcl oral solution*
- *promethazine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU Trihexyphenidyl

Products Affected

- *trihexyphenidyl hcl oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Clomipramine

Products Affected

- *clomipramine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Desipramine

Products Affected

- *desipramine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Doxepin

Products Affected

- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Imipramine

Products Affected

- *imipramine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Librax

Products Affected

- *chlordiazepoxide-amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Phenobarbital

Products Affected

- *phenobarbital oral elixir*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Protriptyline

Products Affected

- *protriptyline hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age Triavil

Products Affected

- *perphenazine-amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Human Growth Hormone

Products Affected

- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Humira

Products Affected

- HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML
- HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Hyrnuo

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, HER2 (ERBB2) tyrosine kinase mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has received prior systemic therapy AND is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ibrance

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Ibtrozi

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC, individual using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iclusig

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For ALL, Philadelphia chromosome (Ph) status. For CML, T315I status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Idhifa

Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, isocitratedehydrogenase-2 (IDH2) mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imbruvica

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 280 MG, 420 MG 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial treatment of growth failure associated with severe primary IGF-1 deficiency as defined by: Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND normal or elevated growth hormone levels (greater than 10ng/mL on standard GH stimulation tests) are present OR GH gene deletion who have development of neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Continuation of treatment with Increlex (mecasermin), Final adult height has not been reached.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inluriyo

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer, ER , HER2 , ESR1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inlyta

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inqovi

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inrebic

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Interferons for MS

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iressa

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of recurrent, advanced, or metastatic Non-small cell lung cancer (NSCLC).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Itovebi

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer (defined as IHC 0 or 1+, or IHC 2+/ISH-), hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status, and PIK3CA-mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual has progressed during adjuvant endocrine treatment or within 12 months of completing adjuvant endocrine therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ITRACONAZOLE

Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For second-line non-onychomycosis indications include tinea infections (including, but limited to tinea versicolor, tinea cruris, tinea corporis, tinea pedis, tinea manuum, and tinea capitis) where the individual has had a trial and inadequate response or intolerance to at least one prior topical therapy: ciclopirox, clotrimazole, ketoconazole, econazole, or nystatin. OR Individual is transitioning from inpatient treatment to an outpatient setting and requires continued therapy for an organism susceptible to itraconazole for a non-onychomycosis use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

IVIG

Products Affected

- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML, 2.5 GM/50ML, 30 GM/300ML, 5 GM/100ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Iwilfin

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jadenu

Products Affected

- *deferasirox oral tablet 90 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For dx non-transfusion-dependent thalassemia (NTDT) syndrome, 10 years of age or older. For dx of chronic iron overload, 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jakafi

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jaypirca

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jideytro

Products Affected

- JIDEYTRO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Jynarque

Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Kalydeco

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Kisqali

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For early breast cancer, individual is using for up to 3 years in the absence of disease recurrence or unaccetable toxicity. For advanced, recurrent, unresectable or metastatic breast cancer, individual is one of the following: Male, postmenopausal female, premenopausal treated with ovarian ablation/suppression.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Komzifti

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, NPM1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Korlym

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Cushings has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: 24-hour urinary free cortisol (UFC) test, Dexamethasone suppression test (DST), Late-night salivary cortisol (LNSC) test) that are indicative of a positive test.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Initial therapy: Individual is not a candidate for surgery that is expected to correct the cause of endogenous Cushings Syndrome OR disease persists or recurs following surgery intended to correct the cause of endogenous Cushings Syndrome. For continuation of therapy: Individual continues to meet the initial request approval criteria AND has experienced an improvement in or stabilization of glucose control as assessed by fasting serum glucose test, oral glucose tolerance test or hemoglobin A1c test.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Koselugo

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Krazati

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC and Colon/Rectal cancer, KRAS G12C mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kuvan

Products Affected

- *sapropterin dihydrochloride oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU. For continued use, has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU AND. There is a positive response to therapy as evidenced by reduction in blood PHE levels from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lazcluze

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenvima

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Letairis

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Leukine

Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Lidocaine 4

Products Affected

- *lidocaine hcl external solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using for anesthesia of accessible mucous membranes of the oral and nasal cavities and proximal portions of the digestive tract.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidoderm Patch

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lifyorli

Products Affected

- LIFYORLI (125 MG DOSE)
- LIFYORLI (150 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Livtencity

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using to treat cytomegalovirus (CMV) infection or disease AND is a hematopoietic stem cell transplant (HSCT) or solid organ transplant (SOT) recipient AND is refractory to treatment with ganciclovir, valganciclovir, cidofovir or foscarnet.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lorbrena

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, ALK status, ROS1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lotronex

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is a Female with Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) defined as including diarrhea and 1 or more of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS. Member is female AND Member has chronic symptoms of IBS that have persisted for 6 months or longer AND does not have an anatomic or biochemical abnormality of the gastrointestinal tract.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a trial and inadequate response or intolerance TWO (2) of the following medications: (a) Loperamide (b) antispasmodics (for example, dicyclomine), or (c) tricyclic antidepressants (AGA 2021).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Lumakras

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC and mCRC, KRAS G12C mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC, individual has confirmed (written or verbal) disease progression after one or more prior lines of systemic therapy and using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lupron Depot

Products Affected

- *leuprolide acetate (3 month)*
- LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Lupron Kit IR

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of Prostate cancer and being used as androgen deprivation therapy as a single agent or in combination with antiandrogen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lynparza

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Ovarian, Breast cancer, Prostate, and Pancreatic cancer, BRCA mutation status. For mCRPC, germline or somatic homologous recombination repair (HRR) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lytgobi

Products Affected

- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For intrahepatic cholangiocarcinoma, FGF/FGFR2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mavyret

Products Affected

- MAVYRET ORAL PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Megace Suspension HRM

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of cachexia, or unexplained weight loss in individuals with HIV/AIDS. Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Megace Tabs HRM

Products Affected

- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	Individual has advanced, inoperable, recurrent breast cancer and using for palliative management. Individual has endometrial/uterine cancer and is using for palliative management.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mekinist

Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, NSCLC, TC, Solid Tumors, and Glioma, BRAF V600 mutation status. For LGG, BRAF V600E mutation status. For cutaneous melanoma, BRAF V600E, V600K mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mektovi

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma and NSCLC, BRAF V600, V600E/K mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC (NCT03915951), individual is treatment naive or had previously treated with 1 prior line of systemic therapy in the advanced/metastatic setting AND has not received prior treatment with any BRAF inhibitor (e.g. dabrafenib, vemurafenib) or MEK inhibitor (cobimetinib, selumetinib).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Mepron

Products Affected

- *atovaquone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Methylphenidate

Products Affected

- *methylphenidate hcl er oral tablet extended release*
- *methylphenidate hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD) or Narcolepsy.
Age Restrictions	For ADHD, 6 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Modafinil

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Modeyso

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diffuse midline glioma, H3 K27M mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has progressive disease following prior therapy AND using Modeyso (dordaviprone) as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Mozobil

Products Affected

- *plerixafor*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	Individual may use a maximum of up to four consecutive doses of plerixafor (Mozobil) injections per cycle for up to 2 cycles. Individual is using Mozobil (plerixafor) for autologous hematopoietic stem cell (HSC) mobilization as part of the development of an FDA-approved ex vivo gene therapy (e.g. Zynteglo).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MSB AntiPSYchotics Cobenfy

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following generic oral atypical antipsychotic: Aripiprazole, Asenapine tablets, Lurasidone, Olanzapine, Paliperidone ER, Quetiapine IR, Risperidone, or Ziprasidone OR the preferred generics are not FDA approved and do not have an accepted off-label use for the prescribed indication and the non-preferred agent does.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MSB AntiPSYchotics Fanapt

Products Affected

- FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B ORAL TABLET
- FANAPT TITRATION PACK C ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following generic oral atypical antipsychotic: Aripiprazole, Asenapine tablets, Lurasidone, Olanzapine, Paliperidone ER, Quetiapine IR, Risperidone, or Ziprasidone OR the preferred generics are not FDA approved and do not have an accepted off-label use for the prescribed indication and the non-preferred agent does.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Namenda Line

Products Affected

- *memantine hcl er*
- *memantine hcl oral solution 2 mg/ml*
- *memantine hcl oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individuals that are 50 years of age or older are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 49 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of moderate to severe dementia of the Alzheimers type.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nayzilam

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has HER2- overexpressed/amplified confirmed by one of the following: (A) Immunohistochemistry (IHC) is 3+ or (B) In situ hybridization (ISH) positive. For breast cancer, HER2 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nexavar

Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nexletol

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Nexlizet

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Northera

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use, individual has had a trial and inadequate response or intolerance to one prior symptomatic nOH pharmacologic therapy (which may include midodrine or fludrocortisone [ACC/AHA/HRS]). For continued use, individual has experienced a positive clinical response with droxidopa use (e.g., sustained decrease in dizziness).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Noxafil

Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

NP LA Opioid Methadone

Products Affected

- *methadone hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

NP LA Opioid Morphine

Products Affected

- *morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Nubeqa

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Individual has Metastatic hormone sensitive prostate cancer (mCSPC) in combination with docetaxel OR (2) metastatic hormone sensitive prostate cancer (mCSPC) OR (3) non-metastatic castration resistant prostate cancer (nmCRPC) AND has a PSA doubling time (PSADT) less than or equal to 10 months AND (4) One of the following: (a) individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (Degarelix] OR (b) Has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Nucala

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using for the treatment of amyotrophic lateral sclerosis (ALS) (Orphan indication) OR Individual has a diagnosis of pseudobulbar affect (PBA) AND has a concomitant diagnosis with an unrelated neurologic disease or injury [amyotrophic lateral sclerosis (AAN 2020, Pioro et al. 2010), multiple sclerosis (AAN 2019, Pioro et al, 2010), stroke (2016 AHA/ASA)].
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Nurtec

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Nuvigil

Products Affected

- *armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Octreotide Line

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of acromegaly has been confirmed by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (such as but not limited to: Insulin-like Growth Factor 1 levels, Oral Glucose Tolerance Test with associated Growth Hormone (GH) levels) that are indicative of a positive test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ofev

Products Affected

- *nintedanib esylate*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Ogsiveo

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has an ECOG performance status of 0-2.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojemda

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For LGG, BRAF fusion or rearrangement, or BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojjaara

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has hemoglobin less than 10 g/dL (NCT04173494, NCT01969838).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Onfi

Products Affected

- *clobazam oral suspension 2.5 mg/ml*
- *clobazam oral tablet 10 mg, 20 mg*
- SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Onureg

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of acute myeloid leukemia (AML), including de novo AML and AML secondary to prior myelodysplastic disease or chronic myelomonocytic leukemia (NCT01757535) AND is used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Opipza

Products Affected

- OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is: 13 years of age or older for schizophrenia. 6 years of age or older for Tourette's disorder and irritability with autistic disorder. 18 years of age or older for major depressive disorder (MDD).
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For use in schizophrenia, individual has had a trial of and inadequate response or intolerance to ONE of the following generic oral atypical antipsychotics: Aripiprazole, Asenapine tablets, Lurasidone, Olanzapine, Paliperidone ER, Quetiapine IR, Risperidone, Ziprasidone.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Opsumit

Products Affected

- *macitentan*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Orenitram

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Orfadin

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Orgovyx

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Orkambi

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Orserdu

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Otezla

Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK
- OTEZLA XR
- OTEZLA/OTEZLA XR INITIATION PK

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Pemazyre

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual with relapsed or refractory myeloid/lymphoid neoplasms (MLNs) OR unresectable locally advanced, or metastatic cholangiocarcinoma AND using as monotherapy AND has confirmed disease progression (written or verbal) after one or more prior lines of systemic therapy. For metastatic cholangiocarcinoma, FGFR2 mutation status. For MLNs, FGFR1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Piqray

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status, and PIK3CA-mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pomalyst

Products Affected

- *pomalidomide*
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. If requesting MSB Pomalyst, then mbr has had a trial and intolerance to pomalidomide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prevymis

Products Affected

- PREVYMIS ORAL PACKET
- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Prolia

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Promacta

Products Affected

- *eltrombopag olamine oral packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Protopic

Products Affected

- *tacrolimus external ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as second-line therapy for moderate to severe atopic dermatitis AND has had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid. OR Use of topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2023, Eleftheriadou 2022): (A) mbr has atopic dermatitis, psoriasis, or vitiligo recalcitrant to topical corticosteroids OR (B) has atopic dermatitis lesions, psoriasis, or vitiligo in sensitive areas (such as face, anogenital area or skin folds) OR (C) has steroid-induced atrophy OR(D) has history of long-term or uninterrupted topical steroid use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Purixan

Products Affected

- *mercaptopurine oral suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qinlock

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent AND has a ECOG performance status of 0-2.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

quinine

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention of nocturnal recumbency leg muscle cramps or other related conditions including but not limited to: Leg cramps, muscle cramps, myoclonus, Periodic Movements of Sleep, Periodic Limb Movements of Sleep (PLMS), Restless Leg Syndrome (RLS).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For uncomplicated malaria caused by: Plasmodium falciparum known or suspected to be resistant to chloroquine (CDC) OR chloroquine-resistant (CQR) Plasmodium vivax (CDC) OR an unidentified plasmodial species known or suspected to be resistant to chloroquine (CDC) OR (CQR) Plasmodium ovale (CDC) OR Chloroquine-sensitive (CQS) Plasmodium malariae (CDC) OR (CQS) Plasmodium knowlesi (CDC) OR (CQS) Plasmodium falciparum, vivax or ovale AND one of the following (CDC): (i.) Individual is pregnant OR (ii.) Chloroquine and hydroxychloroquine are not available. Mbr is using as interim tx for severe malaria until IV artesunate is available (AHFS, CDC) or using as follow-on tx after IV artesunate. Individual has a dx of babesiosis caused by Babesia microti and tx is in conjunction with IV or oral clindamycin (AHFS, DrugPoints B IIa).

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rasonque

Products Affected

- RASONQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of metastatic pancreatic adenocarcinoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Repatha

Products Affected

- REPATHA
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Retevmo

Products Affected

- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, MTC, Thyroid cancer, Solid Tumors, written or verbal attestation is provided for RET mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revatio

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Revcovi

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Revlimid

Products Affected

- *lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For MDS, individual has deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR SF3B1 mutation status and thrombocytosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revuforj

Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Leukemia, KMT2A or NPM1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezdiffra

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Rezlidhia

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Rezurock

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For cGVHD after failure of at least two prior lines of systemic therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rinvoq

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For UC, has inadeq resp or intol to one TNF antagonist OR If TNF inadvisable, mbr has inad resp or intol to one other approved syst therapy for UC. For CD, has inad resp or intol to ONE TNF agent OR If TNF inadvisable, mbr has inad resp to one other approved syst therapy for CD. Continuation requests, there is improvement or stabilization in clinical S/Sx of dz and has been receiving and is maintained on a stable dose of Rinvoq.
Age Restrictions	For RA, CD, UC, AS, NR-axSpA, GCA and PsA, individual is 18 years of age or older. For Atopic Dermatitis, individual is 12 years of age or older. For PJIA, individual is 2 years of age or older. For Pediatric PsA, individual is 2 to 17 years of age.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Initial use: RA, has inad resp or intol to ONE TNF agent. For PsA, has inad resp or intol to ONE TNF agent. For ped PsA, mbr has inad resp or intol to ONE TNF agent. For AD, a non-CS syst immunosuppressant (such as cyclosporine, AZA, or mycophenolate mofetil) has fail to achieve and maint remission of low or mild dz state or are CI OR a Biologic therapy has fail to achieve and maint remission of low or mild dz activity state or are CI. For AS, has inad resp or intol of ONE CONV therapy [such as NSAIDs or nonbiologic DMARDs (such as SSZ)] OR has a CI to NSAIDs or SSZ AND has inad respo or intol to ONE TNF agents. For NR-axSpA, has inad resp or intol of ONE CONV therapy [such as NSAIDs or nonbiologic DMARDs] (ACR 2019) OR has a CI to NSAIDs or nonbiologic DMARD. For PJIA, has inad resp or intol of ONE CONV therapy [nonbiologic DMARDS (such as MTX)] OR has a CI to MTX AND has inad resp or intol to ONE TNF agents. For GCA, combo with tapering CS OR used as single agent following d/c of CS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Romvimza

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rozlytrek

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status. For solid tumor, NTRK gene fusion status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sabril

Products Affected

- *vigabatrin oral packet*
- *vigabatrin oral tablet*
- VIGADRONE ORAL PACKET
- VIGADRONE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For infantile spasm 1 month to 2yr old. For seizure 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Scemblix

Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML, Ph status, T315I, ABL1 exon 2 (such as, b2(e13)a3, b 3(e14)a3 isoforms, A337T, P465S, M244V, F359V/I/C mutation status.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Selarsdi

Products Affected

- SELARSDI INTRAVENOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- SELARSDI SUBCUTANEOUS SOLUTION
- SELARSDI SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Signifor IR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Cushings disease has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: 24-hour urinary free cortisol (UFC) test, Dexamethasone suppression test (DST), Late-night salivary cortisol (LNSC) test) that are indicative of a positive test.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Simlandi

Products Affected

- SIMLANDI (1 PEN)
- SIMLANDI (1 SYRINGE)
- SIMLANDI (2 PEN)
- SIMLANDI (2 SYRINGE)

SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of pulmonary multidrug or rifampicin-resistant tuberculosis (MDR/RR-TB) or pulmonary extensively drug-resistant tuberculosis (XDR-TB) or pulmonary pre-extensively drug-resistant tuberculosis (pre-XDR-TB) AND the individual is using in combination with other anti-infectives (WHO 2025).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Skyrizi

Products Affected

- SKYRIZI INTRAVENOUS
- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 55 MG/0.37ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Solaraze

Products Affected

- *diclofenac sodium external gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Soriatane

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe psoriasis, if individual is a female of reproductive age, has met one of the following: (A) Individual is unresponsive to other therapies OR (B) has a clinical condition that contraindicates the use of other treatments.
Age Restrictions	For severe psoriasis, individual is greater than 18 years of age.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Spravato

Products Affected

- SPRAVATO (84 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual is using for the tx of depressive sx with major depressive disorder (MDD) with acute suicidal ideation or behavior AND has a dx of MDD without psychotic features according to DSM-5 (Fu 2020, Ionescu 2020) AND is judged to be at risk for suicide by a clinician based on consideration of suicidal behavior, expressed suicidal ideation or overall clinical assessment consistent with significant continuing risk of suicide AND will use Spravato in addition to antidepressant therapy. Individual has been diagnosed with moderate to severe major depressive disorder (TRD) AND had an inadequate response to the maximum tolerated dose of two antidepressant therapies during the current major depressive episode (MDE) as defined by less than 50% reduction in symptom severity using a standard rating scale that reliably measures depressive symptoms AND will use Spravato as monotherapy OR in addition to antidepressant therapy.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation (TRD), individual has had at least a 50% reduction in symptoms of treatment resistant moderate to severe depression compared to baseline using a standard rating scale that reliably measures depressive symptoms AND will use Spravato as monotherapy OR in addition to antidepressant therapy.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sprycel

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- PHYRAGO ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	For CML/ALL, Philadelphia chromosome status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For gastrointestinal stromal tumors (GIST), individual has had progression after monotherapy with imatinib and sunitinib (or ripretinib for patients intolerant to second-line sunitinib)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sutent

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Synagis

Products Affected

- SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	Individual has received Beyfortus (nirsevimab) for prevention of respiratory syncytial virus (RSV) lower respiratory tract disease for this RSV season AND does have access to Beyfortus (nirsevimab).
Required Medical Information	Using for: A) Max of 5 doses for infants during the first RSV season w/in first year of life: Born before 29 wks, 0 days gestation (up to and including 28 wks, 6 days) and younger than 12 mon of age at the start of the RSV season OR CLD of prematurity defined as birth at less than 32 wks, 0 days gestation and a req for GTR than 21% oxygen for 28 days after birth OR Hemodyn signif CHD (inc infants with acyanotic heart dz who are rec med to control CHF and will req cardiac surgical procedures with mod to sev PAH OR infants with anatomic pulmonary abnormalities or a neuromuscular condition that impairs the ability to clear secretions from the upper airway of ineffective cough OR CF with evidence of CLD or nutritional compromise (wt for length less than tenth %). B) Max of 5 doses for younger than 24 mon of age with: Profoundly immunocompromised, including SCID, advanced AIDs, undergoing organ or HSCT, or an ABS lymph ct of less than 100 cell/mm3 OR undergoing cardiac transpl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 Months.

PA Criteria	Criteria Details
Other Criteria	C) An additional dose of palivizumab may be allowed for children younger than 24 months of age who have approval for a course of treatment and who undergo cardiopulmonary bypass for a surgical procedure. D) A maximum of 5 doses of palivizumab prophylaxis may be approved for children during their second RSV season (the second RSV season may fall in the first or second year of life) with any of the following: (i) for preterm infant born at less than 32 weeks, 0 days gestation who required at least 28 days of oxygen after birth and continues to require medical intervention within 6 months of the start of the second RSV season (including supplemental oxygen, chronic corticosteroid therapy, or diuretics) or (ii) Cystic fibrosis with severe lung disease (history of hospitalization, abnormal chest x-ray or CT scan) or weight for length less than tenth percentile.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Syprine

Products Affected

- *trientine hcl oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Tabrecta

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For recurrent, advanced or metastatic non-small cell lung cancer (NSCLC), Individual has mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors AND individual has not received treatment with another MET exon 14 skipping-targeted agent, such as crizotinib. For metastatic NSCLC, individual has MET exon 14 skipping positive tumors. For advanced or metastatic NSCLC, individual has high level MET amplification (greater than or equal to 10 gene copies) (Wolf 2020).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using Tabrecta (capmatinib) as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tafinlar

Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, NSCLC, ATC, Solid Tumors, LGG, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Talzenna

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer BRCA mutation status. For mCRPC, HRR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For mCRPC, individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarceva

Products Affected

- *erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR-sensitizing mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Targretin

Products Affected

- *bexarotene external*
- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarpeyo

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Tasigna

Products Affected

- *nilotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML, Ph status, T315I, Y253H, E255K/V, F359V/C/I status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tazorac

Products Affected

- *tazarotene external cream 0.1 %*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Tecvayli

Products Affected

- TECVAYLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tepmetko

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Teriflunomide Agents

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Thalomid

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, Cholangiocarcinoma, and MDS, IDH1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Topical Androgens

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For primary or hypogonadotropic hypogonadism, individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Initial use: Individual has a dx of (1) primary hypogonadism (congenital or acquired) [for example, Cryptorchidism OR Bilateral torsion OR orchitis OR Vanishing testis syndrome OR Orchiectomy OR Klinefelter Syndrome OR Chemotherapy OR Toxic damage from alcohol or heavy metals OR idiopathic primary hypogonadism]. Or (2) Hypogonadotropic hypogonadism (congenital or acquired) [for example, Idiopathic luteinizing hormone-releasing hormone (LHRH deficiency), OR Pituitary-hypothalamic injury.] Individual is using for a dx of gender Dysphoria/incongruence (WPATH 2022) AND has experienced puberty to at least Tanner Stage 2. For continuation use for primary or hypogonadotropic hypogonadism, Individual meets all criteria for initial therapy AND has had serum testosterone level measured in the previous 180 days AND Individual has obtained clinical benefits as noted by symptom improvement.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Topical Tretinoin Agents

Products Affected

- *tretinoin external cream 0.05 %, 0.1 %*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Exclusion Criteria	Topical tretinoin agents may not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, Melasma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trikafta

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK
- TRIKAFTA ORAL THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Truqap

Products Affected

- TRUQAP ORAL TABLET 200 MG
- TRUQAP ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Tukysa

Products Affected

- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Turalio

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyenne

Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Tykerb

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cancer has been confirmed HER2 positive. HER 2 overexpression confirmed (written or verbal) by one of the following: (a) Immunohistochemistry (IHC) 3+ or (b) In situ hybridization (ISH) positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Uceris

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vanflyta

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 internal tandem duplication (ITD)-positive mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vaxchora

Products Affected

- VAXCHORA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Vaccine is being used for active immunization against disease caused by vibrio cholerae serogroup 01. Individual is traveling to a cholera affected area.
Age Restrictions	Ages 2 through 64 years of age.
Prescriber Restrictions	
Coverage Duration	3 Months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Velsipity

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Veppanu

Products Affected

- VEPPANU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer, ER, HER2, ESR1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Verquvo

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, HR status and HER2 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For early Breast Cancer, individual is only using Verzenio in this combination for a total of 24 months (2 years)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vfend

Products Affected

- *voriconazole intravenous solution reconstituted*
- *voriconazole oral suspension reconstituted*
- *voriconazole oral tablet 200 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is currently transitioning from inpatient treatment (hospital/medical facility) to an outpatient (home) setting and requires continued therapy for an organism susceptible to Vfend (voriconazole). Or mbr is using for a FDA approved use or supported by CMS approved compendia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vitrakvi

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Vitrakvi (larotrectinib) oral solution requests, individual is unable to swallow the oral capsule dose form due to a clinical condition, but not limited to the following: (a) Dysphagia OR (b) individual?s age.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vizimpro

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vonjo

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voranigo

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Astrocytoma, Oligodendroglioma, IDH1/IDH2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using Voranigo (vorasidenib) as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a genotype and positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VOTRIENT

Products Affected

- *pazopanib hcl oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vowst

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Wegovy

Products Affected

- WEGOVY ORAL TABLET 1.5 MG, 25 MG, 4 MG, 9 MG
- WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Welireg

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Winrevair

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Xalkori

Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL CAPSULE SPRINKLE
  150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK or ROS1 mutation status. For ALCL and IMT, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xdemvy

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

XENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For initial therapy: Individual is using in combination with somatostatin analog (SSA) therapy (such as but not limited to, lanreotide (Somatuline Depot), octreotide (Sandostatin)) AND individual has had an inadequate response on a stable dose of SSA monotherapy for at least 3 months. For continuation therapy requests: Individual has previously met the initiation criteria AND if improvements are confirmed after 12 weeks of treatment with Xermelo (telotristat ethyl) when added to SSA therapy AND Individual does not have reports of severe constipation or severe persistent or worsening abdominal pain.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Xifaxan 200mg

Products Affected

- XIFAXAN ORAL TABLET 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month.
Other Criteria	For 200mg strength, travelers diarrhea (TD), individual has already been started on the requested agent and needs to complete treatment OR Individual has had a trial and inadequate response or intolerance to one of the following agents (1 or 2) or has contraindications to all of the following agents (both 1 and 2) (CDC, 2026): (1) Generic Fluoroquinolone (ciprofloxacin, levofloxacin) OR (2) Azithromycin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xifaxan HE

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Xolair

Products Affected

- XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML
- XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML
- XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 mutation status.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xpovio

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xtandi

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xyrem

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Yesintek

Products Affected

- YESINTEK INTRAVENOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- YESINTEK SUBCUTANEOUS SOLUTION
- YESINTEK SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Zarxio

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Zejula

Products Affected

- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For ovarian cancer, HRD status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, and ECD, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zenbexus

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ztalmy

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Zurzuvae

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. Individual is 12 months postpartum or less AND has a diagnosis of postpartum depression consistent with a qualifying score using a standardized screening tool for depression (such as, but not limited to, Hamilton Rating Scale for Depression [HAM-D], Patient Health Questionnaire [PHQ-9], Beck Depression Inventory [BDI], Montgomery-Asberg Depression Rating Scale [MADRS], Edinburgh Postnatal Depression Scale [EPDS]).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zykadia

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zymfentra

Products Affected

- ZYMFENTRA (2 PEN)
- ZYMFENTRA (2 SYRINGE)

PA Criteria	Criteria Details
Exclusion Criteria	PENDING CMS REVIEW
Required Medical Information	PENDING CMS REVIEW
Age Restrictions	PENDING CMS REVIEW
Prescriber Restrictions	PENDING CMS REVIEW
Coverage Duration	PENDING CMS REVIEW
Other Criteria	PENDING CMS REVIEW
Indications	PENDING CMS REVIEW
Off Label Uses	PENDING CMS REVIEW
Part B Prerequisite	PENDING CMS REVIEW
Prerequisite Therapy Required	PENDING CMS REVIEW

Zytiga

Products Affected

- *abiraterone acetate oral tablet 250 mg, 500 mg*
- ABIRTEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zyvox

Products Affected

- *linezolid oral suspension reconstituted*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	vancomycin-resistant enterococcus faecium (VRE) infection OR methicillin-resistant S. aureus (MRSA) infection. Or Infection that is caused by other susceptible gram-positive organisms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	If individual started treatment with Linezolid in the hospital and requires continued outpatient therapy for an organism susceptible to linezolid. For pulmonary multidrug-resistant tuberculosis (MDR-TB), rifampin-resistant tuberculosis (RR-TB) or pulmonary extensively drug-resistant tuberculosis (XDR-TB), linezolid will be used in combination with other anti-infectives (AFHS, DP B IIa, ATS/CDC/ERS/IDSA 2019/2025). For non-tuberculous mycobacterial infection (including but not limited to M. fortuitum) (ATS/ERS/ESCMID/IDSA 2020) AND will be used in combination with other anti-infectives (ATS/ERS/ESCMID/IDSA 2020).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes