KAISER PERMANENTE®

Kaiser Permanente Medicare Advantage HMO

2025 Prior Authorization Requirements

PLEASE READ:
Kaiser Permanente requires you to get prior authorization for certain drugs. This means that you will need to get approval from Kaiser Permanente before you fill your prescriptions. If you don't get approval, Kaiser Permanente may not cover the drug. The medications in this document have requirements that must be met for coverage to be considered. Beneficiaries must use network pharmacies to access their prescription drug benefit.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

Formulary ID 00025408 Last updated: 08/2024

Prior Authorization Criteria
Kaiser Washington
Effective: 01/01/2025

ABATACEPT

Products Affected

- Orencia
- Orencia Clickject

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) psoriatic arthritis who have failure, contraindication or intolerance to guselkumab and one other preferred biologic (i.e., secukinumab, adalimumab, infliximab), OR 2) rheumatoid arthritis who have failure, contraindication or intolerance to one anti-TNF (e.g. adalimumab, infliximab), OR 3) polyarticular juvenile idiopathic arthritis who have failure, contraindication or intolerance to methotrexate. Covered for the prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in patients undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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ABEMACICLIB (NEW STARTS ONLY)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Progression following alternative CDK inhibitors.
Required Medical Information	For ER-positive and HER2-negative residual invasive (non-PCR) breast cancer, as adjuvant therapy when combined with endocrine therapy, OR ER-positive and HER2-negative breast cancer as extended adjuvant therapy when combined with endocrine therapy, patient must have germline BRCA 1/2 negative or unknown, AND patient has either 4 or more positive lymph nodes or 1-3 positive lymph nodes and grade 3 and/or a tumor size of at least 5 cm.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) ER-positive and HER2-negative metastatic or locoregionally recurrent breast cancer not amenable to curative intent (i.e., surgery) and combined with endocrine therapy AND intolerance or contraindication to palbociclib or ribociclib (e.g., history of uncontrolled neutropenia, increased infection risk) except in patients requiring CNS penetration, OR 2) ER-positive and HER2-negative breast cancer as adjuvant therapy when combined with endocrine therapy, OR 3) ER-positive and HER2-negative breast cancer as extended adjuvant therapy when combined with endocrine therapy.

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ABRILADA

Products Affected

- Abrilada
- Abrilada 1-pen Kit
- Abrilada 2-pen Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

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ABROCITINIB

Products Affected

- Cibinqo TABS 100MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist or dermatologist.
Coverage Duration	One year
Other Criteria	Covered for patient with moderate or severe atopic dermatitis who have failure, contraindication or intolerance to dupilumab OR tralokinumab-ldrm.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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ACALABRUTINIB (NEW STARTS ONLY)

Products Affected

- Calquence CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Progression on B-cell receptor (BCR) inhibitor (e.g., ibrutinib, zanubrutinib).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of 1) Relapsed/refractory mantle cell lymphoma (MCL) with at least one prior therapy, and contraindication or intolerance to zanubrutinib, OR 2) Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), OR 3) Waldenström's macroglobulinemia in patients who are symptomatic (e.g., hyperviscosity, neuropathy, symptomatic adenopathy or organomegaly, amyloidosis, cryoglobulinemia, cold agglutinin disease, and presence of cytopenia), and contraindication or intolerance to zanubrutinib.

ADAGRASIB (NEW STARTS ONLY)

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of patients with metastatic NSCLC who express KRAS G12C mutations, as second line therapy after chemotherapy/Immunotherapy and if contraindicated or intolerant to sotorasib.

ADALIMUMAB

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

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AFATINIB (NEW STARTS ONLY)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of 1) locally advanced or metastatic non-small cell lung cancer (NSCLC) in patients with intolerance to osimertinib, OR 2) Stage IV NSCLC with actionable EGFR mutations as first line therapy, OR 3) metastatic squamous NSCLC progressing after platinum-based chemotherapy.

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AKEEGA (NEW STARTS ONLY)

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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ALECTINIB (NEW STARTS ONLY)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA approved test.

ALPELISIB (NEW STARTS ONLY)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HR-positive and HER2-negative, documentation of PIK3CA mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for men or postmenopausal women with metastatic or advanced breast cancer that is PIK3CA mutated and HER2 negative, after endocrine-based therapy plus a CDK4/6 inhibitor (e.g., palbociclib, ribociclib). Used in combination with antiestrogen therapy (not to be used with an aromatase inhibitor if ESR1 mutation positive).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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AMIFAMPRIDINE PHOSPHATE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Seizure disorder, pregnancy or end-stage renal disease.
Required Medical Information	Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a Neurologist.
Coverage Duration	One year
Other Criteria	N/A

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AMIKACIN LIPOSOMAL

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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AMJEVITA

Products Affected

- Amjevita INJ 10MG/0.2ML, 20MG/0.2ML, 40MG/0.4ML, 80MG/0.8ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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ANAKINRA

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with neonatal onset multisystem inflammatory disease (NOMID) and deficiency of interlukein-1 receptor antagonist (DIRA). Not covered for patients with rheumatoid arthritis. Preferred alternatives for rheumatoid arthritis are adalimumab, etanercept, and infliximab.

APALUTAMIDE (NEW STARTS ONLY)

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of patients with metastatic hormone sensitive prostate cancer (mHSPC) who are intolerant or have contraindication to abiraterone in combination with prednisone AND enzalutamide.

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APREMILAST

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Behcet's syndrome, at least 3 or more occurrence of oral ulcers in the previous 12-month period.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) Behcet's syndrome with active oral ulcers and who have failure, contraindication, or intolerance to at least one of the following: topical corticosteroid such as triamcinolone dental paste or colchicine, OR 2) psoriatic arthritis who have failure, contraindication, or intolerance to one anti-TNF (i.e., adalimumab or infliximab) AND methotrexate, OR 3) psoriasis who have failure, contraindication, or intolerance to adalimumab OR infliximab.

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ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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ASCIMINIB (NEW STARTS ONLY)

Products Affected

- Scemblix

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

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ASENAPINE (NEW STARTS ONLY)

Products Affected

- Asenapine Maleate Sl
- Secuado

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to at least two preferred antipsychotics (e.g., risperidone, quetiapine, olanzapine, ziprasidone, and aripiprazole).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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ASFOTASE ALFA

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	(1) Onset of clinical signs and symptoms of HPP prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, waddling gait, low trauma fractures. Note: premature dental abnormalities cannot be sole qualifier for treatment initiation in adults) OR radiographic evidence supporting diagnosis of HPP at the age of onset prior to 18 (e.g., craniosynostosis, infantile rickets, non-traumatic fractures), and (2) Blood test showing age adjusted serum levels of alkaline phosphatase (ALP) below the lower limit of normal at time of diagnosis AND diagnosis of HPP confirmed by presence of elevated ALP substrate levels (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level]), and (3) Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, an endocrinologist, or a specialist experienced in the treatment of metabolic bone disorders.
Coverage Duration	One year
Other Criteria	N/A

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ATOGEPANT

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documented assessment to exclude medication-overuse headaches based on International Headache Society Classification ICHD-3 (use of triptans, ergotamine, opioids or any combination of these agents for 10 or more days/month for more than 3 months, non-opioid analgesic use for 15 or more days/month for more than 3 months).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients who have 1) failure, contraindication, or intolerance to at least one preferred preventative agents including topiramate, valproic acid and derivatives, and beta-blocker, AND 2) documentation of an adequate trial and failure fremanezumab-vfrm (Ajovy). An adequate trial is defined as at least 2 months of maximally tolerated dose or documented intolerance or contraindication. Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant) OR monoclonal CGRP agents (e.g. fremanezumab-vfrm) or botulinum toxin for the treatment of migraine.

AVACOPAN

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Active, untreated and/or uncontrolled chronic liver disease and cirrhosis, especially those with severe hepatic impairment (Child-Pugh C) and includes Hepatitis B and Hepatitis C.
Required Medical Information	Positive test for anti-PR3 or anti-MPO (proteinase 3 or myeloperoxidase antibodies) or positive tissue biopsy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with Rheumatology, Nephrology, or Pulmonology Specialist.
Coverage Duration	One year
Other Criteria	Covered for patients with clinical diagnosis of ANCA vasculitis GPA or MPA, or ANCA-positive vasculitis who have a history of significant intolerance to steroid or relative contraindication to steroid per prescriber judgement (factoring in comorbidities and other clinical considerations), or require a decrease in cumulative steroid dose due to steroid-induced complications.

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AVAPRITINIB (NEW STARTS ONLY)

Products Affected

- Ayvakit

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

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AVATROMBOPAG (NEW STARTS ONLY)

Products Affected

- Doptelet

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

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AVONEX

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to interferon beta-1b (e.g., Extavia, Betaseron). Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage.

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AXITINIB (NEW STARTS ONLY)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) advanced renal cell carcinoma for metastatic disease who are not surgical candidates, OR 2) advanced renal cell carcinoma as monotherapy in 2nd or 3rd line, OR 3) unresectable, radioactive iodine refractory Differentiated Thyroid Carcinoma as second line systemic therapy.

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AZACITIDINE (NEW STARTS ONLY)

Products Affected

- Onureg

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

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AZTREONAM INHALATION

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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BARICITINIB

Products Affected

- Olumiant TABS 1MG, 2MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe rheumatoid arthritis who have had an inadequate response, intolerance, or contraindication to one anti-TNF (e.g., adalimumab, infliximab) AND tofacitinib, OR 2) severe alopecia areata.

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BELUMOSUDIL

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for chronic graft-versus-host disease (GVHD) after failure of at least two lines of systemic therapy.

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BENRALIZUMAB

Products Affected

- Fasenra INJ 30MG/ML
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with allergist or pulmonologist.
Coverage Duration	One year
Other Criteria	Covered for patients with moderate to severe asthma with failure, intolerance, or contraindication to combination of high-dose ICS/LABA plus tiotropium.

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BEREMAGENE GEPERPAVEC-SVDT

Products Affected

- Vyjuvek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

BEROTRALSTAT

Products Affected

- Orladeyo CAPS 150MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an immunologist or allergy specialist.
Coverage Duration	One year
Other Criteria	Covered for patients with chronic prophylaxis of hereditary angioedema (HAE) who had failure, contraindication or intolerance to lanadelumab-flyo.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

BEXAROTENE GEL (NEW STARTS ONLY)

Products Affected

- Bexarotene GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients with trial, failure, or contraindication to at least 2 skin-directed therapies (e.g. topical corticosteroids, topical mechlorethamine [Valchor], topical carmustine, topical retinoids [e.g., tazarotene], topical imiquimod, local radiation therapy, phototherapy, total skin electronic beam therapy).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BEXAROTENE ORAL (NEW STARTS ONLY)

Products Affected

- Bexarotene CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of cutaneous T-cell lymphoma in patients with trial, failure, or contraindication to at least 1 skin-directed therapies (e.g. topical corticosteroids, topical mechlorethamine [Valchor], topical carmustine, topical retinoids [e.g. bexarotene, tazarotene], topical imiquimod, local radiation therapy, phototherapy, total skin electronic beam therapy).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BIMEKIZUMAB-BKZX

Products Affected

- Bimzelx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of moderate to severe psoriasis in patients who have failure, contraindication, or intolerance to adalimumab AND secukinumab or guselkumab or risankizumab-rzaa.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

BINIMETINIB (NEW STARTS ONLY)

Products Affected

- Mektovi

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BIRCH TRITERPENES

Products Affected

- Filsuvez

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BOSUTINIB (NEW STARTS ONLY)

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	For patients with chronic myelogenous leukemia (CML) who had failure, contraindication or intolerance to imatinib 400-600 mg daily and dasatinib or nilotinib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BOTULINUM TOXIN

Products Affected

- Xeomin INJ 200UNIT

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BRAND FINGOLIMOD (NEW STARTS ONLY)

Products Affected

- Gilenya CAPS 0.25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A documented adverse reaction to the generic alternatives that are not known side effects of the active ingredient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have intolerance to generic fingolimod.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

BREXPIPRAZOLE (NEW STARTS ONLY)

Products Affected

- Rexulti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) major depression disorder as adjunctive or add-on treatment to antidepressant therapy who have failure, contraindication or intolerance to at least one preferred antipsychotic (e.g., aripiprazole, quetiapine) AND at least one other antidepressant, OR 2) schizophrenia who have failure, contraindication or intolerance to at least two other antipsychotics (i.e., risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole), OR 3) agitation associated with Alzheimer's dementia with clinical documentation that agitation places patient at risk for self-harm and/or harm to others AND failure, intolerance, or contraindication to at least two formulary preferred agents, one of which must be atypical antipsychotic.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BRIGATINIB (NEW STARTS ONLY)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is: Anaplastic lymphoma kinase (ALK)-positive with contraindication, failure or intolerance with alectinib and lorlatinib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

BRODALUMAB

Products Affected

- Siliq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of moderate to severe psoriasis in patients who have failure, contraindication, or intolerance to adalimumab AND secukinumab or guselkumab or risankizumab-rzaa.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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BUROSUMAB-TWZA

Products Affected

- Crysvita

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	eGFR less than 30 mL/min/1.73 m2 OR evidence of tertiary hyperparathyroidism
Required Medical Information	Covered for 1) diagnosis of X-linked hypophosphatemia supported by one of the following: genetic testing (PHEX member with X-mutation) of patient, family linked inheritance, or serum FGF23 level greater than 30 pg/mL, OR 2) diagnosis of FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO) not amenable to surgical excision of the offending tumor/lesion.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an endocrinologist or nephrologist
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CABOMETYX (NEW STARTS ONLY)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of 1) advanced clear cell renal cell carcinoma (RCC) as a first line treatment option when combined with nivolumab, or 2) symptomatic or progressive medullary thyroid cancer (MTC) in patients with unresectable locally advanced or metastatic disease and the patients have failure, contraindication, or intolerance to vandetanib, or 3) advanced hepatocellular carcinoma (HCC) in patients Child-Pugh Class A who have progressed on or after sorafenib or lenvatinib, or 4) locally advanced or metastatic non-small cell lung cancer (NSCLC) who meet the following: for C-Met mutation Exon 14 skipping (METex14) if contraindicated to crizotinib as subsequent therapy following chemotherapy or immunotherapy, or for RET rearrangement as subsequent therapy following chemotherapy or immunotherapy.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CANNABIDIOL (NEW STARTS ONLY)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pediatric or adult neurologist
Coverage Duration	One year
Other Criteria	Covered for patients with 1) Lennox-Gastaut syndrome with treatment refractory to at least two preferred antiepileptic drugs (i.e., valproate, clobazam, topiramate, clonazepam, felbamate, lamotrigine, rufinamide), or 2) Dravet syndrome with treatment refractory to at least two preferred antiepileptic drugs (i.e., valproate, clobazam, topiramate, levetiracetam, clonazepam), or 3) Tuberous sclerosis complex with treatment refractory to at least two preferred antiepileptics drugs (i.e., valproic acid, vigabatrin, levetiracetam, clobazam).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CAPMATINIB (NEW STARTS ONLY)

Products Affected

- Tabrecta

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CARIPRAZINE (NEW STARTS ONLY)

Products Affected

- Vraylar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) acute treatment of bipolar mania or mixed episodes associated with bipolar I disorder, patients must have failure, contraindication, or intolerance to two preferred antipsychotics (e.g., risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole), OR 2) depressive episodes associated with bipolar I and II disorder, patient must have failure, intolerance, or contraindication to one mood stabilizer (e.g., lithium, lamotrigine, divalproex) AND either quetiapine OR olanzapine. For schizophrenia, patient must have failure, intolerance, or contraindication to two of the following: risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole, OR 3) major depressive disorder as an adjunctive therapy to antidepressants for patients 18 years of age or older with failure, intolerance, or contraindication to at least one preferred antipsychotic (e.g., aripiprazole, quetiapine) AND at least one other antidepressant.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CASIMERSEN

Products Affected

- Amondys 45

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prior or planned treatment with gene therapy for Duchenne muscular dystrophy. Require nocturnal ventilation (including BiPAP), but excluding CPAP. Non-ambulatory, including wheelchair dependent.
Required Medical Information	Documented deletion/mutation amenable to exon 45 skipping confirmed by a geneticist. Documented Forced Vital Capacity % (FVC%) greater than or equal to 50% predicted.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physiatrist.
Coverage Duration	One year
Other Criteria	Must be on a stable dose of glucocorticoid for at least 6 months.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CENOBAMATE (NEW STARTS ONLY)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to at least two preferred antiepileptic drugs (e.g., carbamazepine, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, topiramate, valproic acid).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CERITINIB (NEW STARTS ONLY)

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is 1) anaplastic lymphoma kinase (ALK)-positive as detected by an FDA approved test AND who have contraindication, failure, or intolerance of alectinib and crizotinib, or 2) ROS1 mutation positive following progression on entrectinib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CERTOLIZUMAB

Products Affected

- Cimzia
- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) psoriatic arthritis or ankylosing spondylitis or non-radiographic axial spondyloarthritis (nr-axSpA) who have failure, intolerance, or contraindication to another anti-TNF agent (e.g., adalimumab, infliximab) AND secukinumab, OR 2) Crohn's disease who have failure, intolerance, or contraindication to another anti-TNF agent, OR 3) rheumatoid arthritis who have failure, intolerance, or contraindication to two other anti-TNF agents. Not covered for patients with psoriasis. Preferred alternatives are adalimumab, secukinumab, guselkumab, ustekinumab, and risankizumab-rzaa.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CHORIONIC GONADOTROPIN

Products Affected

- Chorionic Gonadotropin INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CLADRIBINE (NEW STARTS ONLY)

Products Affected

- Mavenclad

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include relapsing-remitting disease and active secondary progressive disease who have failure, contraindication, or intolerance to rituximab and another preferred disease modifying therapy for MS (e.g., Glatopa, Extavia, Betaseron, dimethyl fumarate). Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

COBIMETINIB (NEW STARTS ONLY)

Products Affected

- Cotellic

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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COMETRIQ (NEW STARTS ONLY)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of medullary thyroid cancer (MTC) in patients who present without mutational target if intolerant of, or contraindication to vandetanib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

CORTICOTROPIN

Products Affected

- Acthar
- Acthar Gel
- Cortrophin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CRIZANLIZUMAB-TMCA

Products Affected

- Adakveo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematology-oncology specialist
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

CRIZOTINIB (NEW STARTS ONLY)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is 1) anaplastic lymphoma kinase (ALK)-positive as detected by an FDA approved test and who have contraindication, failure, or intolerance of alectinib and lorlatinib, OR 2) ROS protoncogener-1 (ROS1) positive as detected by an FDA approved test, OR 3) C-Met mutation as detected by an FDA approved test. Covered for the treatment of systemic anaplastic large cell lymphoma in pediatric patients 1 year of age and older and young adults with relapsed or refractory disease if ALK positive. Covered for the treatment of adult and pediatric patients 1 year of age and older with unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT) that is ALK-positive.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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CYLTEZO

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

CYSTEAMINE DELAYED-RELEASE

Products Affected

- Procysbi CPDR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	A trial of cysteamine bitartrate (Cystagon).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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CYSTEAMINE OPHTHALMIC

Products Affected

- Cystaran

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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DABRAFENIB (NEW STARTS ONLY)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) treatment of neoadjuvant or adjuvant stage IIB, IIC, or III (for up to one year) melanoma in patients with a BRAF V600 mutation as detected by the FDA-approved test in combination with trametinib, OR 2) treatment of stage IV melanoma in patients with a BRAF V600 mutation as detected by the FDA-approved test and who are intolerant or contraindication to vemurafenib plus cobimetinib treatment, OR 3) combination with trametinib for metastatic non-small lung cancer (NSCLC) with BRAF V600E mutation, OR 4) locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation without the option of curative thyroidectomy, OR 5) BRAF V600 E mutation positive unresectable or metastatic solid tumors, OR 6) BRAF V600E mutation positive unresectable or metastatic melanoma as a monotherapy, OR 7) BRAFV600E mutation positive low grade glioma.

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NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

DACOMITINIB (NEW STARTS ONLY)

Products Affected

- Vizimpro

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

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DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not covered for patients with moderate to severe renal impairment (CrCL less than 50 mL/min or a history of seizures.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Not covered for patients with moderate to severe renal impairment (CrCL less than 50 mL/min) or a history of seizures.

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DAROLUTAMIDE (NEW STARTS ONLY)

Products Affected

- Nubeqa

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

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DASATINIB (NEW STARTS ONLY)

Products Affected

- Sprycel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic myelogenous leukemia (CML), patients express mutations not susceptible to imatinib and in Accelerated or Blast phase according to NCCN guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) CML who failed or were intolerant to imatinib (failure assessed after at least 3 months of therapy), OR 2) Philadelphia chromosome positive ALL.

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DECITABINE/CEDAZURIDINE (NEW STARTS ONLY)

Products Affected

- Inqovi

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

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DEFLAZACORT

Products Affected

- Deflazacort
- Emflaza TABS 36MG, 6MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a neurologist with neuromuscular expertise.
Coverage Duration	One year
Other Criteria	Covered for patients with documented diagnosis of Duchenne muscular dystrophy (DMD) who had trial of prednisone.

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DENOSUMAB

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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DEUTETRABENAZINE

Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication or intolerance to tetrabenazine.

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DICHLORPHENAMIDE

Products Affected

- Dichlorphenamide
- Ormalvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patient who have failure, contraindication, or intolerance to acetazolamide.

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DIROXIMEL FUMARATE

Products Affected

- Vumerity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Requires a documented adverse reaction to the generic dimethyl fumarate that is not a known side effect of the active ingredient.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have intolerance to dimethyl fumarate.

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DROXIDOPA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with symptomatic neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy who have failure, contraindication, or intolerance to midodrine. NOH is defined by a sustained drop in SBP (less than or equal to 20 mmHg) or in DBP (less than or equal to 10 mmHg) upon standing for greater than or equal to 3 minutes.

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DUPILUMAB

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with allergist, pulmonologist, dermatologist, gastroenterologist, or otolaryngologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate or severe atopic dermatitis who have trial and failure of high potency topical steroid AND one of the following: narrow band UVB, mycophenolate, methotrexate, cyclosporine, or azathioprine, OR 2) moderate to severe asthma who have failure, intolerance, or contraindication to combination of high-dose ICS/LABA plus tiotropium, OR 3) chronic rhinosinusitis with nasal polyposis (CRSwNP), OR 4) eosinophilic esophagitis, OR 5) prurigo nodularis.

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DUVELISIB (NEW STARTS ONLY)

Products Affected

- Copiktra

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

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EDARAVONE

Products Affected

- Edaravone
- Radicava
- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	ALS Functional Rating Scale-Revised (ALSFRS-R) score of 2 points or better on each of the 12 items within past two months, duration of 2 years or less from onset of first symptom, and forced vital capacity (%FVC) 80% or greater within past 2 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Clinical ALS diagnosed by a neurologist.

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ELACESTRANT (NEW STARTS ONLY)

Products Affected

- Orserdu

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

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ELTROMBOPAG (NEW STARTS ONLY)

Products Affected

- Alvaiz
- Promacta

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

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ENASIDENIB (NEW STARTS ONLY)

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of patients with relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test.

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ENCORAFENIB (NEW STARTS ONLY)

Products Affected

- Braftovi CAPS 75MG

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

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ENTRECTINIB (NEW STARTS ONLY)

Products Affected

- Rozlytrek

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

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ENZALUTAMIDE (NEW STARTS ONLY)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use in combination with relugolix is not covered
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) the treatment of patients with metastatic castration resistant prostate cancer (CRPC) who progressed on BOTH hormonal therapy (e.g. leuprolide) AND who have progressed on, or who have contraindication to, Abiraterone plus prednisone, OR 2) the treatment of patients with non-metastatic CRPC who are high risk for development of metastasis, defined as a PSADT ≤10 months during continuous androgen-deprivation therapy (bilateral orchiectomy or treatment with gonadotropin-releasing hormone analogue agonists or antagonists) and naïve to or intolerant of other 2nd generation ADT such as darolutamide, apalutamide, OR 3) the treatment of patients with metastatic hormone sensitive prostate cancer (mHSPC) with contraindication or intolerance to Abiraterone plus prednisone.

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EPCLUSA BRAND

Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Consistent with AASLD/IDSA guidance.
Other Criteria	N/A

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EPLONTERSEN

Products Affected

- Wainua

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary transthyretin mediated amyloidosis (hATTR) with polyneuropathy that is thought to be primarily due to amyloidosis, documentation of genetic testing to confirm transthyretin (TTR) mutation, and Karnofsky performance status score 50 or greater, objective weakness in motor strength exam consistent with diagnosis and with confirmation via electrodiagnostic studies (i.e., electromyogram, nerve conduction study), and signs of large fiber neuropathy on exam and/or clinically significant autonomic findings (e.g., orthostatic hypotension, tachycardia, bradycardia, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a neurologist or neuromuscular specialist.
Coverage Duration	One year
Other Criteria	N/A

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ERLOTINIB (NEW STARTS ONLY)

Products Affected

- Erlotinib Hydrochloride TABS

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

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ESKETAMINE (NEW STARTS ONLY)

Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of psychosis or dissociation, unstable angina or history of myocardial infarction, uncontrolled hypertension, increased intracranial pressure, increased in intraocular pressure, active substance or alcohol abuse, use of cannabinoids, cannabis, or cannabis derivatives, positive test result(s) for drugs of abuse, severe hepatic impairment (Child-Pugh Class C), on renal dialysis, women who are pregnant or breast-feeding, contraindication to esketamine use (aneurysmal vascular disease, arteriovenous malformation, history of intracerebral hemorrhage, or hypersensitivity to esketamine, ketamine, or any of the excipients)
Required Medical Information	For patients with treatment-resistant depression (TRD), a diagnosis of major depressive disorder (MDD), severe, without psychotic features, Patient Health Questionnaire-9 (PHQ-9) score of 20 or greater and negative urine drug screen prior to treatment initiation, documented consideration and reason for not proceeding with, or inadequate response to electroconvulsive therapy (ECT) and repetitive transcranial magnetic stimulation (rTMS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist.
Coverage Duration	One year
Other Criteria	Covered for patients with TRD, in conjunction with an oral antidepressant, who had inadequate response to at least 2 antidepressant medications of different classes including SSRIs, SNRIs, atypical antidepressants, monoamine oxidase inhibitors (MAOIs), and/or tricyclic antidepressants (TCAs) at adequate dose and duration for treatment of MDD. Covered for patients with major depressive disorder (MDD) with acute suicidal ideation or behavior, in conjunction with an oral antidepressant.

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ESTRAMUSTINE (NEW STARTS ONLY)

Products Affected

- Emcyt

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

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ETANERCEPT

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for rheumatoid arthritis, moderate to severe psoriasis, psoriatic arthritis, ankylosing spondylitis, and polyarticular juvenile idiopathic arthritis covered for patients who have failure, contraindication, or intolerance to adalimumab OR infliximab. Adalimumab or infliximab is not required for pediatric patients 17 years of age or younger with moderate to severe psoriasis.

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ETEPLIRSEN

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prior or planned treatment with gene therapy for Duchenne muscular dystrophy. Require nocturnal ventilation (including BiPAP), but excluding CPAP. Non-ambulatory, including wheelchair dependent.
Required Medical Information	Documented deletion/mutation amenable to exon 51 skipping confirmed by a geneticist. Documented Forced Vital Capacity % (FVC%) greater than or equal to 50% predicted.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physiatrist.
Coverage Duration	One year
Other Criteria	Must be on a stable dose of glucocorticoid for at least 6 months.

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EVEROLIMUMS (NEW STARTS ONLY)

Products Affected

- Afinitor TABS 10MG
- Afinitor Disperz
- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Everolimus TBSO
- Torpenz

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

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EVOLOCUMAB

Products Affected

- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Homozygous familial hypercholesterolemia: covered for patients age 10 or older with 1) positive genetic testing or untreated low-density lipoprotein cholesterol (LDL-C) levels of greater than 300 mg/dL with documentation of cutaneous or tendon xanthomas before age 10 or evidence of heterozygous familial hypercholesterolemia in both parents and, 2) treatment with maximally tolerated high-intensity statin therapy (i.e., atorvastatin 40 or 80 mg, rosuvastatin 20 or 40 mg) has been ineffective (LDL-C greater than 100 mg/dL) or contraindicated or not tolerated. Statin intolerance is defined as the inability to tolerate at least two statins, one at the lowest starting daily dose (e.g., rosuvastatin 5 mg, atorvastatin 10 mg, simvastatin 10 mg, lovastatin 20 mg, pravastatin 40 mg, fluvastatin 40 mg, and pitavastatin 2 mg) due to either objectionable symptoms or abnormal lab determinations, which are temporally related to statin treatment and reversible upon statin discontinuation, but reproducible by re-challenge with other potential causes being excluded. Primary hyperlipidemia including heterozygous familial hypercholesterolemia: covered for patients age 10 years of older with 1) a probable diagnosis of HeFH based on a validated diagnostic tool (Simon Broome, Dutch Lipid Clinic Network, MEDPED) and, 2) treatment with maximally tolerated high-intensity statin therapy has been ineffective (unable to achieve and maintain LDL-C below goal of less than 100 mg/dL) or contraindicated or not tolerated. Clinical ASCVD: covered for patients age 18 years or older with 1) clinical ASCVD (i.e., coronary heart

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	disease, cerebrovascular disease, or peripheral artery disease) and, 2) treatment with maximally tolerated high-intensity statin therapy has been ineffective (unable to achieve and maintain LDL-C at or below goal of less than 70 mg/dL) or contraindicated or not tolerated.

FEDRATINIB (NEW STARTS ONLY)

Products Affected

- Inrebic

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

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FENTANYL TRANSMUCOSAL

Products Affected

- Fentanyl Citrate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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FERRIC CITRATE

Products Affected

- Auryxia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Treatment of iron deficiency anemia in patients with chronic kidney disease (CKD) not on dialysis.
Required Medical Information	Diagnosis of hyperphosphatemia associated with CKD and on dialysis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, intolerance, or contraindication to calcium-based phosphate binder and sevelamer.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

FOSTAMATINIB (NEW STARTS ONLY)

Products Affected

- Tavalisse

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

FREMANEZUMAB-VFRM

Products Affected

- Ajovy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documented assessment to exclude medication-overuse headache (MOH) based on International Headache Society Classification ICHD-3 (use of triptans, ergotamine, opioids or any combination of these agents for 10 or more days/month for more than 3 months, non-opioid analgesic use for 15 or more days/month for more than 3 months).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to at least two preferred preventative agents including topiramate, valproic acid and derivatives, and beta-blocker. Not covered for concomitant use with botulinum toxin for the treatment of migraine or small molecule CGRP receptor antagonists (i.e., ubrogepant, rimegepant).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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GEFITINIB (NEW STARTS ONLY)

Products Affected

- Gefitinib

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

GILTERITINIB (NEW STARTS ONLY)

Products Affected

- Xospata

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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GIVINOSTAT HCL

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	N/A
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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GIVOSIRAN

Products Affected

- Givlaari

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematology specialist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

GOLIMUMAB

Products Affected

- Simponi
- Simponi Aria

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) ulcerative colitis who have failure, intolerance, or contraindication to two other anti-TNF agents (i.e., adalimumab, infliximab), OR 2) ankylosing spondylitis or psoriatic arthritis who have failure, intolerance, or contraindication to another anti-TNF agent AND secukinumab. Not covered for patients with rheumatoid arthritis. Preferred alternatives are adalimumab and infliximab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

GOLODIRSEN

Products Affected

- Vyondys 53

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prior or planned treatment with gene therapy for Duchenne muscular dystrophy. Require nocturnal ventilation (including BiPAP), but excluding CPAP. Non-ambulatory, including wheelchair dependent.
Required Medical Information	Documented deletion/mutation amenable to exon 53 skipping confirmed by a geneticist. Documented Forced Vital Capacity % (FVC%) greater than or equal to 50% predicted.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physiatrist.
Coverage Duration	One year
Other Criteria	Must be on a stable dose of glucocorticoid for at least 6 months.

GUSELKUMAB

Products Affected

- Tremfya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with psoriatic arthritis or moderate to severe psoriasis who have failure, contraindication or intolerance to adalimumab AND secukinumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

HADLIMA

Products Affected

- Hadlima INJ 40MG/0.8ML
- Hadlima Pushtouch INJ 40MG/0.8ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

HARVONI BRAND

Products Affected

- Harvoni

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Consistent with AASLD/IDSA guidance.
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

HYRIMOZ

Products Affected

- Adalimumab-adaz
- Hyrimoz INJ 40MG/0.8ML
- Hyrimoz Pediatric Crohns Disease Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

IBRUTINIB (NEW STARTS ONLY)

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of 1) PCNSL after first progression or lack of response to first line therapeutic options, or 2) chronic lymphocytic leukemia (CLL) as monotherapy who have contraindication or intolerance to zanubrutinib or acalabrutinib, or 3) mantle cell lymphoma in patients who have relapsed or progressed after at least one non-BTKi prior therapy and who have contraindication or intolerance to zanubrutinib or acalabrutinib, or 4) Waldenström's macroglobulinemia in patients who are symptomatic (e.g., hyperviscosity, neuropathy, symptomatic adenopathy or organomegaly, amyloidosis, cryoglobulinemia, cold agglutinin disease, and presence of cytopenia) who have contraindication or intolerance to zanubrutinib or acalabrutinib, or 5) marginal zone lymphoma (MZL) in patients who have relapsed/refractory disease after at least one anti-CD20-based therapy, or 6) chronic graft versus host disease (cGVHD) after failure of one or more systemic therapy. Not covered for treatment-naive chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) as combination therapy with obinutuzumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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ICOSAPENT ETHYL

Products Affected

- Icosapent Ethyl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) hypertriglyceridemia (500 mg/dL or greater) who have failure, contraindication or intolerance to an FDA-approved omega-3 ethyl esters, or 2) established cardiovascular disease (CVD) who are taking maximum tolerated statin. (statin-intolerant patients are not eligible) and fasting triglyceride 150 mg/dL or greater.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IDACIO

Products Affected

- Idacio (2 Pen)
- Idacio (2 Syringe)
- Idacio Starter Package For Crohns Disease
- Idacio Starter Package For Plaque Psoriasis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

IDELALISIB (NEW STARTS ONLY)

Products Affected

- Zydelig

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IMATINIB (NEW STARTS ONLY)

Products Affected

- Imatinib Mesylate

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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INFIGRATINIB (NEW STARTS ONLY)

Products Affected

- Truseltiq

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IPTACOPAN

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IVACAFTOR

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IVERMECTIN

Products Affected

- Ivermectin TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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IVOSIDENIB (NEW STARTS ONLY)

Products Affected

- Tibsovo

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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IXAZOMIB (NEW STARTS ONLY)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have contraindication or intolerance to bortezomib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

IXEKIZUMAB

Products Affected

- Taltz

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with psoriatic arthritis or ankylosing spondylitis or active non radiographic axial spondyloarthritis (nr-axSpA) who have failure, intolerance, or contraindication to one anti-TNF agent (e.g., adalimumab, infliximab) AND secukinumab. Not covered for patients with psoriasis. Preferred alternatives are adalimumab, secukinumab, guselkumab, ustekinumab, and risankizumab-rzaa.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LAPATINIB (NEW STARTS ONLY)

Products Affected

- Lapatinib Ditosylate

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LAROTRECTINIB (NEW STARTS ONLY)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with solid tumors that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have no satisfactory alternative treatments or that have progressed following treatment.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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LEDIPASVIR/SOFOSBUVIR

Products Affected

- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who had intolerance or contraindication to sofosbuvir/velpatasvir (Epclusa).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LENIOLISIB

Products Affected

- Joenja

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	(1) Diagnosis has been confirmed by presence of an APDS associated genetic variant in either PIK3CD or PIK3R1, AND (2) patient has nodal and/or extranodal lymphoproliferation, history of repeated oto-sino-pulmonary infections and/or organ dysfunction (e.g., lung, liver).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

LENVATINIB (NEW STARTS ONLY)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) treatment of advanced clear cell renal cell carcinoma (RCC) in combination with everolimus in the second or third line setting, OR in combination with pembrolizumab for patients who are not surgical candidates, OR 2) systemic treatment of patients with advanced hepatocellular carcinoma, OR 3) treatment of locally recurrent, unresectable or metastatic, progressive differentiated thyroid carcinoma that is refractory to radioactive iodine treatment in patients whose disease is not amenable to (or has progressed after) external beam radiation (EBRT) without actionable mutation present, OR 4) treatment of recurrent endometrial cancer after first line in combination with pembrolizumab if microsatellite instability stable (MSS/pMMR), OR 5) treatment of patients with Salivary Gland Cancer if adenoid cystic carcinoma, recurrent metastatic disease, and not a candidate for surgery or radiation, OR 6) treatment of anaplastic thyroid carcinoma (ATC) in combination with pembrolizumab if no actionable mutation present or as subsequent line of therapy in patient who have contraindication or intolerance to chemotherapy, OR 7) treatment of stage IV thymic carcinoma as subsequent therapy after chemotherapy.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

L-GLUTAMINE

Products Affected

- Endari
- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	History of acute chest syndrome (documented by pulmonary infiltrate on chest X-ray films) OR two or more sickle cell pain crises within prior 12 months requiring intervention (e.g., home-managed, hospitalizations,emergency department, or urgent care visits).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a hematology-oncology specialist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LIDOCAINE TRANSDERMAL

Products Affected

- Lidocaine PTCH 5%
- Lidocan

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

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LIRAGLUTIDE

Products Affected

- Liraglutide
- Victoza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with type 2 diabetes who are currently on maximum tolerated dose of metformin (or contraindication, failure, or intolerance of maximum tolerated dose of metformin) AND have failure, contraindication or intolerance to SGLT2 inhibitor (e.g., empagliflozin).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LOFEXIDINE

Products Affected

- Lucemyra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Covered for patients with a diagnosis of acute opioid withdrawal and documentation of intolerance to clonidine.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LOMUSTINE (NEW STARTS ONLY)

Products Affected

- Gleostine CAPS 100MG, 10MG, 40MG

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LONAFARNIB

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LORLATINIB (NEW STARTS ONLY)

Products Affected

- Lorbrena

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LUMACAFTOR/IVACAFTOR

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LUMASIRAN

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or urologist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

LUMATEPERONE (NEW STARTS ONLY)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) schizophrenia who have failure, contraindication, or intolerance to at least two preferred antipsychotics (e.g., risperidone, quetiapine, olanzapine, ziprasidone, and aripiprazole), or 2) patients with depressive episode associated with bipolar I or II disorder in adults who have failure, contraindication, or intolerance to one mood stabilizer (e.g., lithium, lamotrigine, divalproex) and either quetiapine or olanzapine.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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LUSPATERCEPT-AAMT

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

MANNITOL

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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MAVACAMTEN

Products Affected

- Camzyos CAPS 10MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) consistent with AHA/ACC guidelines including 1) Left ventricular ejection fraction (LVEF) 55% or greater, and 2) New York Heart Association (NYHA) class II or III, Peak Valsalva LVOT gradient 50 mmHg or greater.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	One year
Other Criteria	Covered for patients with oHCM who are symptomatic despite highest tolerated dose of a non-vasodilating beta-blocker (or non-dihydropyridine calcium channel blocker if beta-blocker is not tolerated.

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MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

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Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

MEPOLIZUMAB

Products Affected

- Nucala INJ 100MG/ML, 40MG/0.4ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist, pulmonologist, rheumatologist, hematologist, or otolaryngologist.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with severe asthma with failure, intolerance, or contraindication to combination of high-dose ICS/LABA plus tiotropium, or 2) with eosinophilic granulomatosis with polyangiitis who have failure, intolerance, or contraindication to at least one of the following immunosuppressants: azathioprine, cyclophosphamide, or methotrexate, or 3) with hypereosinophilic syndrome (HES), or 4) for the maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) who have failure, intolerance, contraindication to dupilumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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MIDOSTAURIN (NEW STARTS ONLY)

Products Affected

- Rydapt

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

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MIFEPRISTONE 300MG

Products Affected

- Korlym
- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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MIRIKIZUMAB-MRKZ

Products Affected

- Omvoh

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with moderate to severe active ulcerative colitis who have intolerance or contraindication or inadequate response with or loss of response to one anti-TNF agent (e.g., adalimumab, infliximab) AND ustekinumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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MITAPIVAT

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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Last Updated: 08/29/2024

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MODAFINIL

Products Affected

- Modafinil TABS

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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MOMELOTINIB (NEW STARTS ONLY)

Products Affected

- Ojjaara

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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NEDOSIRAN

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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NEMOLIZUMAB-ILTO

Products Affected

- Nemluvio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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NERATINIB (NEW STARTS ONLY)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for high risk (Stage II-IIIC) breast cancer patients who have completed adjuvant trastuzumab alone. Must be started within 1 year of completing adjuvant trastuzumab alone.

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Last Updated: 08/29/2024

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NILOTINIB (NEW STARTS ONLY)

Products Affected

- Tasigna

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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NILUTAMIDE (NEW STARTS ONLY)

Products Affected

- Nilutamide

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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NINTEDANIB

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use of nintedanib and pirfenidone in combination is not covered.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

NIRAPARIB (NEW STARTS ONLY)

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for ovarian, fallopian tube, or primary peritoneal cancer as 1) first line maintenance treatment for patients who meet all of the following criteria: documentation of platinum-sensitive, completion of platinum-based chemotherapy, BRCA mutation positive or HRD, and stage III or IV disease, OR 2) as maintenance treatment for patients who meet all of the following criteria: no prior PARP inhibitor, complete or partial clinical response to second line treatment, BRCA mutation positive.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of PseudoBulbar Affect (PBA).

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OFATUMUMAB

Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, intolerance to ocrelizumab AND rituximab. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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OLAPARIB (NEW STARTS ONLY)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) recurrent ovarian, fallopian tube, or primary peritoneal cancer as monotherapy in patients with documentation of a BRCA mutation AND previous treatment with 2 or more lines of chemotherapy, OR 2) ovarian, fallopian tube, or primary peritoneal cancer as first-line maintenance treatment for patients who meet all of the following criteria: documentation of platinum-sensitive, completion of platinum-based chemotherapy, BRCA mutation positive or HRD, and Stage III or IV disease, OR 3) ovarian, fallopian tube, or primary peritoneal cancer as maintenance treatment for patients who meet all of the following criteria: no prior PARP inhibitor, complete or partial clinical response to second line treatment, and BRCA mutation positive, OR 4) as 2nd line treatment for recurrent, unresectable or metastatic breast cancer that is ER/PR positive, HER2 negative or HER2 low after progression on or after endocrine therapy AND germline BRCA 1/2 mutation positive, OR 5) as monotherapy for metastatic or recurrent triple-negative breast cancer (TNBC) AND documentation of a germline BRCA mutation, OR 6) Stage I to III breast cancer as adjuvant therapy if all the following are met: BRCA positive, estrogen receptor positive, and high grade (3 plus), OR 7) treatment of metastatic adenocarcinoma of the pancreas which is BRCA 1/2 or PALB2 mutated as maintenance after platinum therapy, OR 8) as 2nd line treatment of metastatic castrate resistant prostate cancer with BRCA1, BRCA2, or ATM alterations, after treatment with abiraterone, enzalutamide or other first line options.

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OLUTASIDENIB (NEW STARTS ONLY)

Products Affected

- Rezlidhia

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

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OMACETAXINE (NEW STARTS ONLY)

Products Affected

- Synribo

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

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OMALIZUMAB

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist, pulmonologist, dermatologist or otolaryngologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe asthma who have failure, intolerance, or contraindication to benralizumab OR dupilumab, OR 2) chronic idiopathic urticaria who have failure, contraindication or intolerance to an adequate duration of one histamine-1 receptor antagonist such as cetirizine and levocetrizine (4 weeks minimum), OR 3) nasal polyps with inadequate response to nasal corticosteroids, as add-on maintenance treatment, OR 4) IgE-mediated food allergy for the reduction of allergic reactions (Type I), including anaphylaxis.

OMAVELOXOLONE

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients with pers cavus, non-ambulatory, brain natriuretic peptide (BNP) level less than 200 pg/m, history of clinically significant left-sided heart disease and/or clinically significant cardiac disease, with the exception of mild to moderate cardiomyopathy associated with Friedreich's ataxia.
Required Medical Information	Diagnosis of Friedreich's ataxia genetically confirmed, modified Friedreich's Ataxia Rating Scale (mFARS) score between 20 and 80 (including), left ventricular ejection fraction 40% or less within 6 months prior to initiating therapy.
Age Restrictions	Covered for patients between 16 years and 40 years of age.
Prescriber Restrictions	Prescribed by a neurologist, pediatric neurologist, or genetics specialist.
Coverage Duration	One year
Other Criteria	N/A

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OPSYNVI

Products Affected

- Opsynvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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OSILODROSTAT

Products Affected

- Isturisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation that pituitary surgery is not an option or has not been curative.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to either ketoconazole OR pasireotide.

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Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

OSIMERTINIB (NEW STARTS ONLY)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) treatment of patients with metastatic EGFR non-small lung cancer (NSCLC), expressing targetable mutations, as detected by an FDA approved test, OR 2) adjuvant NSCLC, expressing EGFR targetable mutations after first line chemotherapy treatment as maintenance, or if not a candidate for chemotherapy. Maximum 3 years of therapy.

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OZANIMOD (NEW STARTS ONLY)

Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or gastroenterologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to fingolimod, OR 2) moderate to severe ulcerative colitis who have failure, contraindication, or intolerance to at least one preferred anti-TNF (infliximab, adalimumab) AND ustekinumab. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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PACRITINIB (NEW STARTS ONLY)

Products Affected

- Vonjo

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

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PALBOCICLIB (NEW STARTS ONLY)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with metastatic or locoregionally recurrent breast cancer not amenable to curative intent (i.e., surgery) who have ER-positive and HER2-negative OR HER2 low without visceral crisis disease, AND when used in combination with some type of anti-estrogen therapy (i.e., anastrozole, letrozole, or fulvestrant) AND either as demonstrated intolerance or has contraindication to ribociclib.

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PAROXETINE (NEW STARTS ONLY)

Products Affected

- Paroxetine Hcl TABS 30MG, 40MG
- Paroxetine Hcl Er
- Paroxetine Hydrochloride SUSP
- Paroxetine Hydrochloride TABS 10MG, 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Applies to patients 65 years of age and older. Prior authorization not required for patients age 0 to 64 years.
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Paroxetine is considered a high risk medication in the elderly. Patients must try and fail two other SSRIs (e.g., fluoxetine, escitalopram, or sertraline). The prescriber must attest that they are aware that the medication is considered a high risk medication in the elderly and that the benefits outweigh the risk.

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PATISIRAN

Products Affected

- Onpattro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary transthyretin mediated amyloidosis (hATTR) with polyneuropathy that is thought to be primarily due to amyloidosis, documentation of genetic testing to confirm transthyretin (TTR) mutation, and Karnofsky performance status score 50 or greater, objective weakness in motor strength exam consistent with diagnosis and with confirmation via electrodiagnostic studies (i.e., electromyogram, nerve conduction study), and signs of large fiber neuropathy on exam and/or clinically significant autonomic findings (e.g., orthostatic hypotension, tachycardia, bradycardia, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a neurologist or neuromuscular specialist.
Coverage Duration	One year
Other Criteria	N/A

PAZOPANIB (NEW STRATS ONLY)

Products Affected

- Pazopanib Hydrochloride

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

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PEGVALIASE-PQPZ

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use with sapropterin (Kuvan). Sapropterin should be discontinued prior to initiation of pegvaliase-pqpz.
Required Medical Information	Documented diagnosis of classical phenylketonuria (PKU) confirmed by metabolic specialist, Pre-treatment baseline phenylalanine (Phe) level above 600 micromol/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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PERAMPANEL (NEW STARTS ONLY)

Products Affected

- Fycompa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to at least two formulary preferred antiepileptic drugs (e.g., carbamazepine, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, topiramate, valproic acid).

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PIMAVANSERIN (NEW STARTS ONLY)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist or movement disorder specialist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, failure, intolerance, or reasonable expectation of intolerance of a trial of reducing any potential exacerbating medications of psychosis or delusions, including but not limited to, Parkinson's disease medications for treatment of motor symptoms (e.g., carbidopa/levodopa, amantadine, dopamine agonists), AND trial of quetiapine or clozapine.

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PIRFENIDONE

Products Affected

- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use of nintedanib and pirfenidone in combination is not covered.
Required Medical Information	A confirmed Idiopathic pulmonary fibrosis (IPF) diagnosis by one of the following: Definite Usual Interstitial Pneumonia (UIP) pattern on high-resolution computed tomography (HRCT), or possible UIP pattern on HRCT AND definite or probable UIP pattern based on histopathologic features on surgical biopsy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	One year
Other Criteria	N/A

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PITOLISANT

Products Affected

- Wakix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physician board certified in sleep disorders.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with narcolepsy with cataplexy or 2) with excessive daytime sleepiness (EDS) in narcolepsy who have failure, contraindication, or intolerance to armodafinil or modafinil and another formulary stimulant.

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PLEGRIDY

Products Affected

- Plegridy
- Plegridy Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to interferon beta-1b (e.g., Extavia, Betaseron). Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage.

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POMALIDOMIDE (NEW STARTS ONLY)

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for the treatment of patients with 1) multiple myeloma who have received at least one prior therapy including bortezomib and an immunomodulatory agent (e.g. thalidomide, lenalidomide), or 2) AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative.

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PONATINIB (NEW STARTS ONLY)

Products Affected

- Iclusig

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

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PRALSETINIB (NEW STARTS ONLY)

Products Affected

- Gavreto

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

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PROCARBAZINE (NEW STARTS ONLY)

Products Affected

- Matulane

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

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PROGESTERONE

Products Affected

- Endometrin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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QUININE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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REBIF

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to interferon beta-1b (e.g., Extavia, Betaseron). Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage.

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REGORAFENIB (NEW STARTS ONLY)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) advanced hepatocellular carcinoma (HCC) and Child-Pugh Class A liver function status if given as 2nd line and beyond therapy AND if immunotherapy ineligible , OR 2) metastatic colorectal cancer who have been previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy, OR 3) locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate AND sunitinib malate AND have SDH deficiency, OR 4) Esophageal, GEJ, or Gastric Adenocarcinoma in the third-line setting, OR 5) resectable GIST with SDH deficiency and regorafenib is used as neoadjuvant.

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RELUGOLIX (NEW STARTS ONLY)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not covered in combination with potent androgen receptor inhibitors (e.g., abiraterone, enzalutamide, apalutamide, darolutamide) or in combination with docetaxel or cabazitaxel.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with advanced or metastatic prostate cancer who have documented treatment failure after a trial of degarelix or intolerance to degarelix, AND documented treatment failure after an adequate trial of leuprolide or intolerance to leuprolide. Leuprolide trial must include trying the 1-month depot and a multiple month depot (e.g., 3-month, 4-month, or 6-month). NOTE: intolerance excludes hot flashes and local injection site reactions.

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RESMETIROM

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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RIBOCICLIB (NEW STARTS ONLY)

Products Affected

- Kisqali

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

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RIBOCICLIB/LETROZOLE (NEW STARTS ONLY)

Products Affected

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

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

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RIMEGEPANT

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the preventative treatment of episodic migraine: Documented assessment to exclude medication-overuse headaches based on International Headache Society Classification ICHD-3 (use of triptans, ergotamine, opioids or any combination of these agents for 10 or more days/month for more than 3 months, non-opioid analgesic use for 15 or more days/month for more than 3 months).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with acute treatment of migraine who have failure, contraindication, or intolerance to at least one oral triptans at maximally tolerated doses and ubrogepant. Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant, atogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm). OR 2) for the preventative treatment of episodic migraine who have failure, contraindication, or intolerance to atogepant AND fremanezumab-vfrm (Ajovy). Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant, atogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm) or botulinum toxin for the treatment of migraine.

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RIOCIGUAT

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) pulmonary arterial hypertension (WHO Group 1) with failure, contraindication or intolerance to a phosphodiesterase-5 inhibitor (e.g., sildenafil, tadalafil) and one formulary endothelin-receptor antagonists, or 2) Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) when patient is not a candidate for pulmonary endarterectomy OR patient has resistant/recurrent CTEPH despite pulmonary endarterectomy based on pulmonology or cardiology recommendations.

RIPRETINIB (NEW STARTS ONLY)

Products Affected

- Qinlock

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

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RISANKIZUMAB-RZAA

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe psoriasis or psoriatic arthritis who have failure, intolerance, or contraindication to adalimumab AND secukinumab, OR 2) Crohn's disease who have intolerance or contraindication or inadequate response with or loss of response to one anti-TNF agent (e.g., adalimumab, infliximab) AND ustekinumab.

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RISDIPLAM

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prior or planned treatment with gene therapy for SMA (e.g., onasemnogene abeparvovec), concurrent treatment with nusinersen, permanent invasive ventilation or tracheostomy.
Required Medical Information	Confirmed diagnosis of 5q-autosomal recessive SMA (biallelic deletions or mutations in the SMN1 gene), Confirmation of two to four copies of the SMN2 gene.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with pediatric neurology, neurology, or other physician specialist with expertise in managing spinal muscular atrophy (SMA).
Coverage Duration	One year
Other Criteria	N/A

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RITLECITINIB

Products Affected

- Litfulo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who had failure, contraindication or intolerance to baricitinib.

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RUCAPARIB (NEW STARTS ONLY)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of ovarian, fallopian tube, or primary peritoneal cancer as monotherapy for patients with recurrent disease AND documented germline BRCA mutation who meet all of the following criteria: previous treatment with 2 or more lines of chemotherapy, AND unable to take olaparib and niraparib OR have platinum-resistant disease.

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RUXOLITINIB (NEW STARTS ONLY)

Products Affected

- Jakafi

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

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SARILUMAB

Products Affected

- Kevzara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) rheumatoid arthritis who have tried and failed two of the following agents (adalimumab, infliximab, tocilizumab), OR 2) polymyalgia rheumatica (PMR) who have contraindication, intolerance, or inadequate response to corticosteroids or who cannot tolerate corticosteroid taper, AND contraindication, intolerance, or inadequate response to methotrexate.

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SECUKINUMAB

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe psoriasis, psoriatic arthritis, enthesitis-related arthritis (ERA), ankylosing spondylitis or active non-radiographic axial spondyloarthritis (nraxSpA) who have failure, intolerance, or contraindication to one anti-TNF agent (e.g., adalimumab, infliximab), OR 2) severe Hidradenitis Suppurativa (HS) who have contraindication, intolerance, or failure after 12 weeks total of at least one systemic antibiotic (doxycycline, minocycline, or clindamycin/rifampicin), AND trial and failure of at least 16 weeks of adalimumab OR infliximab.

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SELEXIPAG

Products Affected

- Uptravi
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	One year
Other Criteria	Covered for patients with pulmonary arterial hypertension (PAH, WHO Group 1) as confirmed by right heart catheterization, AND WHO functional class II, III, or IV, AND contraindication, intolerance, or failure of dual therapy with an endothelin-receptor antagonist (e.g., ambrisentan, bosentan) and a phosphodiesterase type 5 inhibitor (e.g., sildenafil).

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NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

SELINEXOR (NEW STARTS ONLY)

Products Affected

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

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

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SELPERCATINIB (NEW STARTS ONLY)

Products Affected

- Retevmo

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

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SEMAGLUTIDE

Products Affected

- Ozempic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with type 2 diabetes who have failure, contraindication or intolerance to SGLT2 inhibitor (e.g., empagliflozin) AND liraglutide.

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SILDENAFIL

Products Affected

- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG

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

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SIMLANDI

Products Affected

- Adalimumab-ryvk
- Adalimumab-ryvk (2 Pen)
- Simlandi 1-pen Kit
- Simlandi 2-pen Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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SIPONIMOD (NEW STARTS ONLY)

Products Affected

- Mayzent TABS 2MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to fingolimod.

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SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine Hydrochloride TABS
  10MG, 5MG
- Methocarbamol TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Applies to patients 65 years of age and older. Prior authorization not required for patients age 0 to 64 years.
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Members will be evaluated for more than one fill within the current plan year. The prescriber must attest that they are aware that the medication is considered a high risk medication in the elderly and that the benefits outweigh the risk.

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SODIUM OXYBATE

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physician board certified in sleep disorders.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with narcolepsy with cataplexy or 2) with excessive daytime sleepiness in narcolepsy who have contraindication, intolerance or failure to modafinil or armodafinil and another formulary stimulant.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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SODIUM PHENYLBUTYRATE/TAURURSODIOL

Products Affected

- Relyvrio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Moderate to severe hepatic or renal impairment.
Required Medical Information	Patient is within 18 months from symptom onset, Forced vital capacity (FVC) is greater than 60, Prescriber attestation that riluzole has been considered prior to Relyvrio, patient is currently on riluzole, or documented intolerance to riluzole.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist with expertise in diagnosing amyotrophic lateral sclerosis (ALS).
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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SODIUM ZIRCONIUM CYCLOSILICATE

Products Affected

- Lokelma

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with failure, intolerance, or contraindication to sodium polystyrene sulfonate.

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SOFOSBUVIR

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Test for HBV infection by measuring HBsAG and anti-HBc within 6 months of treatment.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with infectious disease specialist, gastroenterology specialist, or hepatologist.
Coverage Duration	Consistent with AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with AASLD/IDSA guidance.

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SOFOSBUVIR/VELPATASVIR

Products Affected

- Sofosbuvir/velpatasvir

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

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SOMATROPIN

Products Affected

- Humatrope INJ 6MG
- Norditropin Flexpro INJ 10MG/1.5ML, 15MG/1.5ML, 5MG/1.5ML
- Omnitrope
- Zorbtive

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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SONIDEGIB (NEW STARTS ONLY)

Products Affected

- Odomzo

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

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SORAFENIB (NEW STARTS ONLY)

Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

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

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SOTORASIB (NEW STARTS ONLY)

Products Affected

- Lumakras

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

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SUNITINIB (NEW STARTS ONLY)

Products Affected

- Sunitinib Malate
- Sutent

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

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SUTIMLIMAB-JOME

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient is 18 years old or older and weighs at least 39 kg, diagnosis of cold agglutinin disease (CAD) based on all of the following: chronic hemolysis, and polyspecific direct antiglobulin test (DAT) positive, and monospecific DAT strongly positive for C3d, and cold agglutinin titer 64 or less at 4°C, and immunoglobulin G DAT 1+ or less, and no overt malignant disease.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	One year
Other Criteria	N/A

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SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TADALAFIL

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of the signs and symptoms of benign prostatic hyperplasia at the FDA-approved dose for this indication (dose may not exceed 5 mg/day), provided that the patient has had failure, intolerance or contraindication to one alpha-1 adrenergic blocking agents (e.g., prazosin, doxazosin, terazosin, tamsulosin), and has had failure, intolerance or contraindication to one 5-alpha-reductase inhibitor (e.g., finasteride, dutasteride).

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TADALAFIL (PAH)

Products Affected

- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TAFAMIDIS

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	New York Heart Association (NYHA) Class IV or American College of Cardiology/American Heart Association (ACC/AHA) Stage D heart failure (HF), end-stage renal disease, concomitant use with inotersen, patisiran, vutrisiran, or eplontersen, prior heart or liver transplantation, implanted cardiac mechanical assist device, pregnant, breastfeeding, poor prognosis (less than 1-year life expectancy), or use for treatment of ATTR polyneuropathy, without evidence of cardiac involvement.
Required Medical Information	Medical history of HF with at least 1 prior hospitalization for HF or clinical evidence of HF (without hospitalization) manifested by signs or symptoms of volume overload or elevated intracardiac pressures that required treatment with diuretic or other symptoms of HF (e.g., exertional fatigue). AND, diagnosis confirmed by positive biopsy demonstrating transthyretin (TTR)-amyloid deposition OR all 3 of the following: 1) Diagnosis of HF (defined as stage C heart failure) plus NYHA class I, II or III, and either: echocardiogram with d-diastolic interventricular septal wall thickness greater than 12 mm, OR cardiac MRI consistent with, or suggestive of, amyloidosis, AND 2) Pyrophosphate (PYP) scintigraphy cardiac uptake visual score of either: Grade 2 or 3 using the Perugini Grade 1-3 scoring system, OR calculated heart-to-contralateral lung (H/CL) ratio 1.5 or greater, AND 3) Absence of a monoclonal gammopathy after testing for serum immunofixation (IFE) and serum free light chains.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	One year
Other Criteria	N/A

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TALAZOPARIB (NEW STARTS ONLY)

Products Affected

- Talzenna

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

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TAPINAROF

Products Affected

- Vtama

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TASIMELTEON

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physician board certified in sleep disorders.
Coverage Duration	One year
Other Criteria	N/A

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TAZEMETOSTAT (NEW STARTS ONLY)

Products Affected

- Tazverik

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

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TEDUGLUTIDE

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TENAPANOR

Products Affected

- Xphozah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TEPOTINIB (NEW STARTS ONLY)

Products Affected

- Tepmetko

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

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TEPROTUMUMAB-TRBW

Products Affected

- Tepezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Confirmed diagnosis of active thyroid eye disease (TED), clinical activity score 4 or greater, patient is euthyroid, hemoglobin A1c less than 9%, patient had inadequate response, intolerance, or contraindication to either of the following: IV methylprednisolone plus oral mycophenolate OR high dose IV methylprednisolone.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oculoplastic surgeon.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

TEZEPELUMAB-EKKO

Products Affected

- Tezspire

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist or pulmonologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) severe asthma with a non-eosinophilic and non-allergic phenotype and oral corticosteroid (OCS) dependent who have failure, contraindication or intolerance to dupilumab, or 2) severe asthma with a non-eosinophilic and non-allergic phenotype and not OCS dependent who have failure, contraindication or intolerance to combination of high-dose ICS/LABA plus tiotropium, or 3) severe eosinophilic asthma who have failure, intolerance, or contraindication to benralizumab, or 4) severe allergic asthma who have failure, contraindication or intolerance to omalizumab and dupilumab.

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THIOGUANINE (NEW STARTS ONLY)

Products Affected

- Tabloid

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

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THYROTROPIN

Products Affected

- Thyrogen INJ 0.9MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TOBRAMYCIN INHALATION BRAND

Products Affected

- Kitabis Pak
- Tobi Podhaler

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Trial and failure of generic tobramycin inhalation solution.

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TOBRAMYCIN INHALATION GENERIC

Products Affected

- Tobramycin NEBU

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

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TOCILIZUMAB

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) rheumatoid arthritis who have had an inadequate response, intolerance, or contraindication to methotrexate AND tried and failed one anti-TNF agent (e.g., adalimumab, infliximab). Covered for patients with active systemic juvenile idiopathic arthritis or polyarticular juvenile idiopathic arthritis or giant cell arteritis or systemic sclerosis-associated interstitial lung disease (SSc-ILD).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

TOCILIZUMAB-AAZG

Products Affected

- Tyenne

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TOCILIZUMAB-BAVI

Products Affected

- Tofidence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TOFACITINIB

Products Affected

- Xeljanz TABS
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe rheumatoid arthritis or psoriatic arthritis who have had an inadequate response, intolerance, or contraindication to methotrexate AND one anti-TNF agent (e.g., adalimumab, infliximab), OR 2) moderate to severe active ulcerative colitis who have had an inadequate response to one anti-TNF agent (e.g., adalimumab, infliximab), OR 3) ankylosis spondylitis who have failure, intolerance, or contraindication to two of the following: adalimumab, etanercept, infliximab, or secukinumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TOFACITINIB ORAL SOLUTION

Products Affected

- Xeljanz SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with polyarticular juvenile idiopathic arthritis who have had an inadequate response, intolerance or contraindication to methotrexate.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TOFERSEN

Products Affected

- Qalsody

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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Last Updated: 08/29/2024

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TOREMIFENE (NEW STARTS ONLY)

Products Affected

- Toremifene Citrate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of metastatic breast cancer in postmenopausal women with a contraindication to tamoxifen and an aromatase inhibitor (i.e., anastrozole, letrozole or exemestane).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TRALOKINUMAB-LDRM

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist or dermatologist.
Coverage Duration	One year
Other Criteria	Covered for patients with moderate or severe atopic dermatitis who have trial and failure of high potency topical steroid AND one of the following: narrow band UVB, mycophenolate, methotrexate, cyclosporine, or azathioprine.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TRAMETINIB (NEW STARTS ONLY)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for 1) treatment of neoadjuvant or adjuvant stage IIB, IIC, or III (for up to one year) melanoma in patients with a BRAF V600 mutation as detected by the FDA-approved test in combination with dabrafenib, OR 2) treatment of stage IV melanoma in patients with a BRAF V600 mutation as detected by the FDA-approved test and who are intolerant or contraindication to vemurafenib plus cobimetinib treatment, OR 3) combination with dabrafenib for metastatic non-small lung cancer (NSCLC) with BRAF V600E mutation, OR 4) combination with dabrafenib for locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation without the option of curative thyroidectomy, OR 5) BRAF V600 E mutation positive unresectable or metastatic solid tumors, OR 6) BRAF V600E mutation positive unresectable or metastatic melanoma as a monotherapy, OR 7) BRAFV600E mutation positive low grade glioma, OR 8) hepatocellular carcinoma as 3rd line treatment for patients with BRAF V600 mutation positive and Child Pugh A and if combined with dabrafenib, OR 9) metastatic or unresectable esophageal, GEJ, squamous cell carcinoma or gastric adenocarcinoma as 3rd line and if BRAF V600 mutation and if combined with dabrafenib, OR 10) unresectable or metastatic biliary tract cancer in combination with dabrafenib if BRAF V600 mutated.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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TRICYCLIC ANTIDEPRESSANTS (NEW STARTS ONLY)

Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 100MG, 10MG, 25MG, 50MG
- Amoxapine
- Clomipramine Hcl CAPS
- Clomipramine Hydrochloride
- Desipramine Hydrochloride
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Nortriptyline Hcl CAPS 25MG, 75MG
- Nortriptyline Hcl SOLN
- Nortriptyline Hydrochloride CAPS 10MG, 50MG
- Protriptyline Hcl
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Applies to patients 65 years of age and older. Prior authorization not required for patients age 0 to 64 years.
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Tricyclic antidepressants are considered high risk medications in the elderly. For depression: patients must have trial, failure, or contraindication to a SSRI (e.g., fluoxetine, escitalopram, or sertraline). For neuropathic pain or fibromyalgia: after failure of two preferred agents (e.g., gabapentin, duloxetine). For headache prophylaxis, patients must have trial, failure, or contraindication to two preferred agents (e.g., topiramate, divalproex delayed release, propranolol).

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TRIFLURIDINE/TIPIRACIL (NEW STARTS ONLY)

Products Affected

- Lonsurf

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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TROFINETIDE

Products Affected

- Daybue

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered if (1) Patient has failed behavioral, rehabilitative and/or pharmacological therapies targeting Rett syndrome related characteristics (e.g., physical/occupational therapy, applied behavioral analysis [ABA], behavioral health treatment [BHT], anxiolytics), AND (2) At least 6 months "post regression" at treatment initiation (i.e., no loss or degradation in ambulation, hand function, speech, nonverbal communicative or social skills within six months of treatment initiation), AND 3) Clinical Global Impression Scale-Severity (CGI-S) score of greater than or equal to 4 within 1 month prior to initiation, AND (4) Patient has a stable pattern of seizures or has had no seizures within 8 weeks of treatment initiation, AND (5) Normal eGFR and QTc within previous year prior to treatment initiation.

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TUCATINIB (NEW STARTS ONLY)

Products Affected

- Tukysa

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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UBROGEPANT

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to at least two different oral triptans at maximally tolerated doses. Not covered for concomitant use with other small molecule CGRP agents (e.g. atogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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UPADACITINIB

Products Affected

- Rinvoq
- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe rheumatoid arthritis who have an inadequate response, intolerance or contraindication to methotrexate and tofacitinib, OR 2) moderate to severe atopic dermatitis who have failure, intolerance, or contraindication to dupilumab OR tralokinumab-ldrm, OR 3) psoriatic arthritis or ankylosing spondylitis who have failure, intolerance, or contraindication to secukinumab and one anti-TNF (e.g., adalimumab, infliximab), OR 4) moderate to severe ulcerative colitis who have an inadequate response, intolerance or contraindication to one anti-TNF (e.g., adalimumab, infliximab) AND tofacitinib, OR 5) moderate to severe Crohn's disease who have an inadequate response, intolerance, or contraindication to one anti-TNF (e.g., adalimumab, infliximab), OR 6) non-radiographic axial spondyloarthritis who have failure, intolerance, or contraindication to secukinumab AND one anti-TNF (e.g., adalimumab).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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USTEKINUMAB

Products Affected

- Stelara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) psoriatic arthritis who have failure, intolerance, or contraindication to one anti-TNF agent (i.e., adalimumab, etanercept, infliximab) AND secukinumab, OR 2) Crohn's disease who have intolerance or contraindication to two anti-TNF agents (e.g., adalimumab, infliximab), or inadequate response with or loss of response to one anti-TNF agent (e.g., adalimumab, infliximab) AND vedolizumab, OR 3) moderate to severe active ulcerative colitis who have failure, contraindication, or intolerance to one anti-TNF agent (e.g. adalimumab, infliximab) AND vedolizumab, OR 4) moderate to severe psoriasis who have failure, contraindication, or intolerance to adalimumab AND secukinumab.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VALBENAZINE

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication or intolerance to tetrabenazine.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VAMOROLONE

Products Affected

- Agamree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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VEDOLIZUMAB

Products Affected

- Entyvio INJ 108MG/0.68ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) moderate to severe active ulcerative colitis who have contraindication, intolerance, or loss of response to one anti-TNF agent (e.g., adalimumab, infliximab), or 2) Crohn's disease who have intolerance or contraindication to two anti-TNF agents, or inadequate response with or loss of response to one anti-TNF agent.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VEMURAFENIB (NEW STARTS ONLY)

Products Affected

- Zelboraf

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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VENETOCLAX (NEW STARTS ONLY)

Products Affected

- Venclexta
- Venclexta Starting Pack

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

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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VIEKIRA PAK

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Test for HBV infection by measuring HBsAG and anti-HBc within 6 months of treatment.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with infectious disease specialist, gastroenterology specialist, or hepatologist.
Coverage Duration	Consistent with AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with AASLD/IDSA guidance.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VILAZODONE (NEW STARTS ONLY)

Products Affected

- Viibryd Starter Pack
- Vilazodone Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with depression who have failure, contraindication or intolerance to at least two formulary preferred other antidepressants (e.g., fluoxetine, citalopram, venlafaxine, bupropion).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VILTOLARSEN

Products Affected

- Viltepso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prior or planned treatment with gene therapy for Duchenne muscular dystrophy. Require nocturnal ventilation (including BiPAP), but excluding CPAP. Non-ambulatory, including wheelchair dependent.
Required Medical Information	Documented deletion/mutation amenable to exon 53 skipping confirmed by a geneticist. Documented Forced Vital Capacity % (FVC%) greater than or equal to 50% predicted.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physiatrist.
Coverage Duration	One year
Other Criteria	Must be on a stable dose of glucocorticoid for at least 6 months.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

VISMODEGIB (NEW STARTS ONLY)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication or intolerance to sonitigib.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VORASIDENIB (NEW STARTS ONLY)

Products Affected

- Voranigo

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

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VORINOSTAT (NEW STARTS ONLY)

Products Affected

- Zolinza

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

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VORTIOXETINE (NEW STARTS ONLY)

Products Affected

- Trintellix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with depression who have failure, contraindication or intolerance to at least two formulary preferred other antidepressants (e.g., fluoxetine, citalopram, venlafaxine, bupropion).

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with infectious disease specialist, gastroenterology specialist, or hepatologist.
Coverage Duration	One year
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
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VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent Clostridium difficile infection (CDI) confirmed by documentation of positive test. Documentation of one unsuccessful fecal microbiome transplant (FMT) only if access is available.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who completed a 6-month trial of a vancomycin taper and a 10-day course of fidaxomicin OR rifaximin.

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VOXELOTOR

Products Affected

- Oxbryta TABS 500MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Treatment of sickle cell pain crises, treatment of hemoglobin sickle cell disease, patients with a history of cerebrovascular accident (CVA) or acute chest syndrome (ACS) requiring exchange or chronic transfusion.
Required Medical Information	Hemoglobin level less than or equal to 10.5 g/dL prior to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematology-oncology specialist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 25408, Version: 7, Effective Date: 01/01/2025
Last Updated: 08/29/2024

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VUTRISIRAN

Products Affected

- Amvuttra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary transthyretin mediated amyloidosis (hATTR) with polyneuropathy that is thought to be primarily due to amyloidosis, documentation of genetic testing to confirm transthyretin (TTR) mutation, Karnofsky performance status score 50 or greater, objective weakness in motor strength exam consistent with diagnosis and with confirmation via electrodiagnostic studies (i.e., electromyogram, nerve conduction study), and signs of large fiber neuropathy on exam and/or clinically significant autonomic findings (e.g., orthostatic hypotension, tachycardia, bradycardia).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a neurologist or neuromuscular specialist.
Coverage Duration	One year
Other Criteria	N/A

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Last Updated: 08/29/2024

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YUFLYMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita).

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ZANUBRUTINIB (NEW STARTS ONLY)

Products Affected

- Brukinsa

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

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ZAVEGEPANT

Products Affected

- Zavzpret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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ZILEUTON

Products Affected

- Zileuton Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients who have not responded to maximal tolerated doses of at least one inhaled corticosteroids (i.e., beclomethasone, fluticasone, mometasone, ciclesonide) and montelukast.

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ZILUCOPLAN

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	N/A

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ZURANOLONE (NEW STARTS ONLY)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a psychiatrist, or adult primary care or OB/GYN specialist in consultation with a psychiatrist.
Coverage Duration	30 days
Other Criteria	N/A

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PART B VERSUS PART D

Products Affected

- Acetylcysteine INHALATION SOLN
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Aprepitant CAPS
- Arformoterol Tartrate
- Azathioprine INJ
- Azathioprine TABS
- Budesonide SUSP
- Cladribine
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Granisetron Hydrochloride TABS
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myhibbin
- Ohtuvayre
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Pentamidine Isethionate INHALATION SOLR
- Prehevbrio
- Prograf PACK
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Treprostinil
- Tyvaso Refill Kit
- Tyvaso Starter Kit
- Vincasar Pfs
- Vincristine Sulfate INJ 1MG/ML
- Yupelri

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

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Index Of Drugs

NOTE: Part D does not cover some indications that are excluded from coverage or restricted under section 1927(d)(2) of the Act (e.g., infertility, cosmetic purpose, or erectile dysfunction)

B

C

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R

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S

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