Drugs That Require Prior Authorization (PA)
Before Being Approved for Coverage

You will need authorization by your HMSA Akamai Advantage (PPO) plan before filling prescriptions for the drugs shown in the chart below. The HMSA Akamai Advantage plan will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart. You, your appointed representative, or your prescriber can request prior authorization by calling HMSA at 1 (855) 479-3659, 24 hours a day, 7 days a week. Customer service is available in English and other languages. TTY/TDD users should call 711.

PA Criteria

Prior Authorization Group	ABIRATERONE
Drug Names	ABIRATERONE ACETATE, ABIRTEGA, ZYTIGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer, very-high-risk prostate cancer, non-metastatic high-risk prostate cancer, non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence/recurrence after radical prostatectomy, salivary gland tumors
Exclusion Criteria	-
Required Medical Information	For all indications: the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For salivary gland tumors: the requested drug is being used for the treatment of recurrent androgen receptor positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ABRYSVO
Drug Names	ABRYSVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ACITRETIN
Drug Names	ACITRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)
Exclusion Criteria	-
Required Medical Information	For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate or cyclosporine.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	ACTEMRA
Drug Names	ACTEMRA, ACTEMRA ACTPEN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Castleman's disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For giant cell arteritis (GCA) (new starts only): patient has experienced an intolerable adverse event to one of the following products: Rinvoq (upadacitinib) or Tyenne (tocilizumab-aazg) and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For systemic juvenile idiopathic arthritis (sJIA) (new starts only): patient has experienced an intolerable adverse event to Tyenne (tocilizumab-aazg) and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ACTHAR HP
Drug Names	ACTHAR, ACTHAR GEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the following diagnoses, patient has experienced an inadequate treatment response to a parenteral or an oral glucocorticoid (for ophthalmic diseases only, inadequate response to a trial of a topical ophthalmic glucocorticoid is also acceptable): 1) For rheumatic disorders (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): The requested drug must be used as adjunctive treatment, 2) For nephrotic syndrome: the requested drug must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic diseases (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic diseases, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness. For infantile spasms (IS): for continuation of therapy, patient must show substantial clinical benefit from therapy.
Age Restrictions	For infantile spasms (IS) initial request: patient is less than 2 years of age
Prescriber Restrictions	-
Coverage Duration	IS: 6 months, MS exacerbation: 3 weeks, Serum sickness: 1 month, All other diagnoses: 3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ADAKVEO
Drug Names	ADAKVEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	16 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	ADAPALENE
Drug Names	ADAPALENE, ADAPALENE/BENZOYL PEROXID, CABTREO, DIFFERIN PUMP, EPIDUO FORTE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ADBRY
Drug Names	ADBRY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis, initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has experienced an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For atopic dermatitis, continuation of therapy: Patient achieved or maintained positive clinical response.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ADZYNMA
Drug Names	ADZYNMA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For congenital thrombotic thrombocytopenic purpura (cTTP), initial: Diagnosis has been confirmed by genetic testing or enzyme assay with biallelic mutations in the ADAMTS13 gene. For cTTP, continuation: Patient is responding to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AIMOVIG
Drug Names	AIMOVIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AJOVY
Drug Names	AJOVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AKEEGA
Drug Names	AKEEGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AKLIEF
Drug Names	AKLIEF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acne vulgaris: The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to a generic topical retinoid.
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ALBENDAZOLE
Drug Names	ALBENDAZOLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ascariasis, trichuriasis, microsporidiosis
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Hydatid disease, Microsporidiosis: 6 months, All other indications: 1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ALDURAZYME
Drug Names	ALDURAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis I (MPS I): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing. Patients with Scheie form (i.e., attenuated MPS I) must have moderate to severe symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), ALK-positive large B-cell lymphoma
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the patient meets either of the following: a) the disease is recurrent, advanced, or metastatic OR b) the requested drug will be used as adjuvant treatment following tumor resection, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ALKINDI
Drug Names	ALKINDI SPRINKLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For adrenocortical insufficiency: 1) Patient requires a strength that is not available in hydrocortisone tablets (e.g., 0.5 mg, 1 mg, or 2 mg) OR 2) Patient has difficulty swallowing hydrocortisone tablets.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ALOSETRON
Drug Names	ALOSETRON HYDROCHLORIDE, LOTRONEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate treatment response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 milligrams per deciliter [mg/dL] by radial immunodiffusion or 50 mg/dL by nephelometry).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ALPRAZOLAM ER
Drug Names	ALPRAZOLAM ER, XANAX XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For panic disorder: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of panic disorder, OR the patient experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs) AND 2) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored), AND 3) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), Erdheim-Chester disease (ECD) with ALK-fusion
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ALVAIZ
Drug Names	ALVAIZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): the requested drug is used for initiation and maintenance of interferon-based therapy. For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): Pt had an insufficient response to immunosuppressive therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
Other Criteria	For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).
Prerequisite Therapy Required	Yes

Prior Authorization Group	ALYFTREK
Drug Names	ALYFTREK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ALYMSYS
Drug Names	ALYMSYS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	AMBRISENTAN
Drug Names	AMBRISENTAN, LETAIRIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AMPHETAMINES
Drug Names	ADDERALL, ADDERALL XR, ADZENYS XR-ODT, AMPHETAMINE ER ODT, AMPHETAMINE/DEXTROAMPHETA, DEXEDRINE, DEXTROAMPHETAMINE SULFATE, DYANAVEL XR, MYDAYIS, XELSTRYM, ZENZEDI
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AMVUTTRA
Drug Names	AMVUTTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For polyneuropathy of hereditary transthyretin (TTR)-mediated amyloidosis, initial therapy: Patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease (e.g., amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy). For polyneuropathy of hereditary TTR-mediated amyloidosis, continuation of therapy: Patient demonstrates a beneficial response to therapy (e.g., improvement of neuropathy severity and rate of disease progression). For cardiomyopathy of hereditary or wild-type transthyretin-mediated amyloidosis (ATTR-CM), initial therapy: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by one of the following: a) imaging via echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), or b) myocardial technetium-labeled scintigraphy, AND 3) diagnosis has been confirmed by one of the following: a) biopsy confirming transthyretin amyloid deposits and presence of transthyretin precursor proteins, b) positive technetium-labeled bone scintigraphy tracing AND systemic light chain amyloidosis has been ruled out by tests showing absence of monoclonal proteins (e.g., serum kappa/lambda free light chain ratio, serum protein immunofixation, urine protein immunofixation), c) if the request is for hereditary ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene. For ATTR-CM, continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AMZEEQ
Drug Names	AMZEEQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ANDEMBRY
Drug Names	ANDEMBRY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) The patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) The patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) The patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) The patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ANZUPGO
Drug Names	ANZUPGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe chronic hand eczema (CHE): The patient meets either of the following: 1) The patient experienced an inadequate treatment response with a medium or higher potency topical corticosteroid (TCS), OR 2) The use of TCS is not advisable. For chronic hand eczema, continuation of therapy: The patient achieved or maintained a positive clinical response.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 5 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	APOKYN
Drug Names	APOKYN, APOMORPHINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of "off" episodes in Parkinson's disease, continuation: The patient is experiencing improvement on the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AQNEURSA
Drug Names	AQNEURSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Niemann-Pick disease type C (NPC), initial: 1) The diagnosis was confirmed by genetic testing demonstrating a variant of either the NPC1 or NPC2 gene, 2) The patient has neurological manifestations of disease (e.g., loss of fine motor skills, swallowing, speech, ambulation), AND 3) The requested medication will not be used in combination with Miplyffa (arimoclomol), AND 4) Patient weighs greater than or equal to 15kg. For Niemann-Pick disease type C, continuation: The patient is experiencing benefit from therapy (e.g., stabilization or improvement in fine motor skills, swallowing, speech, ambulation).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AQVESME
Drug Names	AQVESME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ARANESP
Drug Names	ARANESP ALBUMIN FREE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia in patients with myelodysplastic syndromes (MDS)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) For anemia due to chronic kidney disease (CKD): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) For all uses: pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL, AND 3) For anemia in patients with myelodysplastic syndrome (MDS): pretreatment serum erythropoietin (EPO) level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses: 1) Patient has received at least 12 weeks of erythropoietin therapy, AND 2) Patient responded to erythropoietin therapy, AND 3) Current Hgb is less than 12 g/dL, AND 4) For CKD: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Anemia in CKD: Plan Year, All other indications: 16 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prerequisite Therapy Required	No

Prior Authorization Group	ARAZLO
Drug Names	ARAZLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	AREXVY
Drug Names	AREXVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ARIKAYCE
Drug Names	ARIKAYCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ARMLUPEG
Drug Names	ARMLUPEG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL, NUVIGIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ARYNTA
Drug Names	ARYNTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic central nervous system (CNS) stimulant drug, other than lisdexamfetamine (e.g., amphetamine, dextroamphetamine, methylphenidate), AND 2) The patient has difficulty swallowing solid oral dosage forms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ASPARLAS
Drug Names	ASPARLAS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute lymphoblastic lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	21 years of age or younger
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ATTRUBY
Drug Names	ATTRUBY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of variant or wild-type transthyretin-mediated amyloidosis (ATTR-CM), initial therapy: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by one of the following: a) imaging via echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), or b) myocardial technetium-labeled scintigraphy, AND 3) diagnosis has been confirmed by one of the following: a) biopsy confirming transthyretin amyloid deposits and presence of transthyretin precursor proteins, b) positive technetium-labeled bone scintigraphy tracing AND systemic light chain amyloidosis has been ruled out by tests showing absence of monoclonal proteins (e.g., serum kappa/lambda free light chain ratio, serum protein immunofixation, urine protein immunofixation), c) if the request is for variant ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene. For ATTR-CM, continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AUBAGIO
Drug Names	AUBAGIO, TERIFLUNOMIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AUGTYRO
Drug Names	AUGTYRO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent ROS1-positive non-small cell lung cancer (NSCLC), recurrent neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC, NTRK gene fusion positive solid tumors that are not locally advanced or metastatic
Exclusion Criteria	-
Required Medical Information	For ROS1-positive non-small cell lung cancer (NSCLC): the patient has recurrent, advanced, or metastatic disease. For neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC: the patient has recurrent, advanced, or metastatic disease. For solid tumors: the tumor is NTRK gene fusion positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AUSTEDO
Drug Names	AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For tardive dyskinesia, initial: patient must meet both of the following: 1) patient exhibits clinical manifestations of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]). For chorea associated with Huntington's disease, initial: patient demonstrates characteristic motor examination features. For tardive dyskinesia and chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	AVASTIN
Drug Names	AVASTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	AVEED
Drug Names	AVEED
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria, the patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AVLAYAH
Drug Names	AVLAYAH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis II (MPS II): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase (I2S) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	AVMAPKI-FAKZYNJA
Drug Names	AVMAPKI FAKZYNJA CO-PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AVONEX
Drug Names	AVONEX, AVONEX PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	AVSOLA
Drug Names	AVSOLA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. For all indications: The patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

Prior Authorization Group	AVTOZMA
Drug Names	AVTOZMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For giant cell arteritis (GCA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Rinvoq (upadacitinib) or Tyenne (tocilizumab-aazg). For systemic juvenile idiopathic arthritis (sJIA) (new starts only): patient has experienced an intolerable adverse event to Tyenne (tocilizumab-aazg) and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	AYVAKIT
Drug Names	AYVAKIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.
Exclusion Criteria	-
Required Medical Information	For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842V mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including a PDGFRA D842V mutation, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in residual, unresectable, tumor rupture, or recurrent/metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	AZELEX CREAM
Drug Names	AZELEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acne vulgaris: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to a generic topical acne product (e.g., topical clindamycin, topical erythromycin, topical retinoid).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	AZSTARYS
Drug Names	AZSTARYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic amphetamine product or a generic methylphenidate product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	B VS. D
Drug Names	ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADMELOG, AKYNZEO, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN II, AMINOSYN-PF, AMINOSYN-PF 7%, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APIDRA, APREPITANT, ARFORMOTEROL TARTRATE, ASTAGRAF XL, ATGAM, AVGEMSI, AVOPEF, AXTLE, AZACITIDINE, AZASAN, AZATHIOPRINE, BEIZRAY, BENDAMUSTINE HYDROCHLORID, BENDEKA, BLEOMYCIN SULFATE, BUDESONIDE, CALCITONIN SALMON, CALCITONIN-SALMON, CALCITRIOL, CAMPTOSAR, CARBOPLATIN, CARNITOR, CELLCEPT, CINACALCET HYDROCHLORIDE, CISPLATIN, CLIGAVYX, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 6/5, CLINIMIX 8/10, CLINIMIX 8/14, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 8/10, CLINIMIX E 8/14, CLINISOL SF 15%, CLINOLIPID, CLONIDINE HYDROCHLORIDE, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOPHOSPHAMIDE MONOHYDR, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, CYTOGAM, DACARBAZINE, DECITABINE, DEPO-MEDROL, DEXRAZOXANE, DEXTROSE 50%, DEXTROSE 70%, DILAUDID, DOCETAXEL, DOCIVYX, DOXERCALCIFEROL, DOXIL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, DUOPA, DURACLON, ELITEK, ELLENCE, EMEND, EMEND BIPACK, EMEND TRIPACK, ENGERIX-B, ENVARSUS XR, EPOPROSTENOL SODIUM, ERBITUX, ERIBULIN MESYLATE, ETHYOL, ETOPOPHOS, ETOPOSIDE, EVEROLIMUS, FASLODEX, FAVLYXA, FIASP, FIASP PUMPCART, FLUDARABINE PHOSPHATE, FLUOROURACIL, FORMOTEROL FUMARATE, FOSCARNET SODIUM, FRINDOVYX, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRAFAPEX, GRANISETRON HYDROCHLORIDE, GRANISOL, HALAVEN, HEPAGAM B, HEPARIN SODIUM, HEPLISAV-B, HUMALOG, HUMULIN R, HYDROMORPHONE HCL, HYDROMORPHONE HYDROCHLORI, IBANDRONATE SODIUM, IFEX, IFOSFAMIDE, IMOVAX RABIES (H.D.C.V.), IMURAN, INSULIN LISPRO, INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, IXEMPRA KIT, JYLAMVO, JYNNEOS, KABIVEN, KADCYLA, KENALOG-10, KENALOG-40, KENALOG-80, KHAPZORY, KIRSTY, KYXATA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, LIDOCAINE/PRILOCAINE, LYUMJEV, MARINOL, MEDROL, MERILOG, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HYDROCHLORID, MORPHINE SULFATE, MORPHINE SULFATE/SODIUM C, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, MYFORTIC, MYHIBBIN, NEBUPENT, NEORAL,

	NIPENT, NOVOLIN R, NOVOLIN R RELION, NOVOLOG, NOVOLOG RELION, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, ONIVYDE, ORAPRED ODT, OXALIPLATIN, PACLITAXEL, PACLITAXEL PROTEIN-BOUND, PAMIDRONATE DISODIUM, PARICALCITOL, PEMETREXED, PEMRYDI RTU, PENTAMIDINE ISETHIONATE, PERFOROMIST, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE DR, PREDNISONE INTENSOL, PREMASOL, PROGRAF, PROSOL, PULMICORT, RABAVERT, RECLAST, RECOMBIVAX HB, ROCALTROL, SANDIMMUNE, SIROLIMUS, SMOFLIPID, SOLU-MEDROL, TACROLIMUS, TACROLIMUS ER, TEMSIROLIMUS, TENIVAC, TOPOTECAN HCL, TOPOTECAN HYDROCHLORIDE, TORISEL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TREXALL, TRIAMCINOLONE ACETONIDE, TROPHAMINE, VALRUBICIN, VALSTAR, VARUBI, VECTIBIX, VELETRI, VIDAZA, VINBLASTINE SULFATE, VINCRISTINE SULFATE, VINORELBINE TARTRATE, VIVIMUSTA, VYKOURA, XATMEP, XYLOCAINE, XYLOCAINE-MPF, ZEMPLAR, ZILRETTA, ZOLEDRONIC ACID, ZORTRESS
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	N/A
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Prerequisite Therapy Required	No
Prior Authorization Group	BACLOFEN
Drug Names	BACLOFEN, OZOBAX DS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient is unable to take oral solid dosage forms for any reason (e.g., difficulty swallowing tablets or capsules, requires administration via feeding tube).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BAFIERTAM
Drug Names	BAFIERTAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BALVERSA
Drug Names	BALVERSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) genetic alterations, AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced, recurrent, or metastatic urothelial carcinoma, OR b) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BANZEL
Drug Names	BANZEL, RUFINAMIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BAVENCIO
Drug Names	BAVENCIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gestational trophoblastic neoplasia, endometrial carcinoma
Exclusion Criteria	-
Required Medical Information	For urothelial carcinoma, the requested drug will be used as either of the following: 1) maintenance therapy if there is no progression on first-line platinum-containing chemotherapy OR 2) subsequent therapy. For renal cell carcinoma: 1) the disease is advanced, relapsed, or stage IV, AND 2) the requested drug will be used in combination with axitinib as first-line therapy. For gestational trophoblastic neoplasia, the requested drug will be used for multiagent chemotherapy resistant disease. For endometrial carcinoma: 1) the requested drug will be used as subsequent therapy, AND 2) the disease is recurrent microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BAXFENDY
Drug Names	BAXFENDY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hypertension (initial): 1) The patient is currently taking other antihypertensive drugs (e.g., angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], beta-blocker, calcium channel blocker, diuretics) at maximally tolerated doses, AND 2) The patient's blood pressure is not adequately controlled with their current regimen. For hypertension (continuation): 1) The patient is currently taking other antihypertensive drugs (e.g., angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], beta-blocker, calcium channel blocker, diuretics) at maximally tolerated doses, AND 2) The patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BELBUCA
Drug Names	BELBUCA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BELEODAQ
Drug Names	BELEODAQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult T-cell leukemia/lymphoma, extranodal NK/T-cell lymphoma, hepatosplenic T-cell lymphoma, breast implant associated anaplastic large cell lymphoma (ALCL).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	For patients new to therapy: severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) patient is currently receiving a standard therapy regimen for SLE (for example, corticosteroid, antimalarial, or NSAIDs), OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE, AND 3) for initial starts, patient has confirmed diagnosis of SLE from positive autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). For lupus nephritis: 1) patient is currently receiving a standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis, AND 3) for initial starts, patient has confirmed diagnosis of LN from either of the following: a) kidney biopsy, b) positive for autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins).
Age Restrictions	5 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BEOVU
Drug Names	BEOVU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	BERINERT
Drug Names	BERINERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BESPONSA
Drug Names	BESPONSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For B-cell precursor acute lymphoblastic leukemia (ALL): The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	BESREMI
Drug Names	BESREMI, BESREMI PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BETASERON
Drug Names	BETASERON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BEXAROTENE
Drug Names	BEXAROTENE, TARGRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS), CD30-positive primary cutaneous anaplastic large cell lymphoma (ALCL), CD30-positive lymphomatoid papulosis (LyP), subcutaneous panniculitis-like T-cell lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	BIMZELX
Drug Names	BIMZELX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) Patient has a contraindication that would prohibit a trial of NSAIDs.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BKEMV
Drug Names	BKEMV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient (pt) has demonstrated a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels). For atypical hemolytic uremic syndrome (aHUS) (initial): The disease is not caused by Shiga toxin-producing Escherichia coli. For aHUS (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The pt has demonstrated a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts). For generalized myasthenia gravis (continuation): 1) There is no evidence of unacceptable toxicity while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy. For neuromyelitis optica spectrum disorder (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BLENREP
Drug Names	BLENREP
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BOSENTAN
Drug Names	BOSENTAN, TRACLEER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) if the request is for an adult patient, the patient meets both of the following: a) pretreatment pulmonary vascular resistance is greater than 2 Wood units, and b) the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ambrisentan (Letairis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF, BOSUTINIB
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) Patient has experienced resistance or intolerance to imatinib, dasatinib, or nilotinib. For B-ALL including patients who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BOTOX
Drug Names	BOTOX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Excessive salivation secondary to advanced Parkinson's disease, hemifacial spasm, chronic anal fissure, achalasia, spasmodic dysphonia (laryngeal dystonia), oromandibular dystonia, palmar hyperhidrosis, essential tremor, myofascial pain
Exclusion Criteria	Cosmetic use
Required Medical Information	For chronic migraine prophylaxis, initial treatment: 1) patient experiences at least 15 headache days per month, AND 2) patient has experienced an inadequate response, intolerance, or a contraindication to a calcitonin gene-related peptide (CGRP) inhibitor. For chronic migraine prophylaxis, continuation of treatment (after 2 injection cycles): More headache-free days per month since starting therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Chronic migraine, initial tx: 6 months, renewal: Plan Year. All other indications: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BRAFTOVI
Drug Names	BRAFTOVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma, recurrent NSCLC
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The patient has either of the following: a) advanced or metastatic disease, b) unresectable metachronous metastases, AND 3) The requested drug will be used in combination with cetuximab or panitumumab. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer (NSCLC): 1) Tumor is positive for BRAF V600E mutation, AND 2) Disease is advanced, recurrent, or metastatic, AND 3) The requested drug will be used in combination with binimetinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BREKIYA
Drug Names	BREKIYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 receptor agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BRINSUPRI
Drug Names	BRINSUPRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For non-cystic fibrosis bronchiectasis (NCFB), initial: 1) the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest, AND 2) patient has symptomatic disease (e.g., cough, dyspnea, excessive airway secretions, frequent respiratory infections, pulmonary exacerbations). For NCFB, continuation: the patient has experienced a positive response to therapy (e.g., decrease in pulmonary exacerbations).
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BRIUMVI
Drug Names	BRIUMVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BRIVIACT
Drug Names	BRIVARACETAM, BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BRIVIACT INJ
Drug Names	BRIVARACETAM, BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BRUKINSA
Drug Names	BRUKINSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hairy cell leukemia
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BUDESONIDE-FORMOTEROL
Drug Names	SYMBICORT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of asthma and maintenance treatment of chronic obstructive pulmonary disease (COPD): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluticasone-salmeterol.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BUPRENORPHINE PATCH
Drug Names	BUPRENORPHINE, BUTRANS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	BYETTA
Drug Names	EXENATIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BYLVAY
Drug Names	BYLVAY, BYLVAY (PELLETS)
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of pruritis in progressive familial intrahepatic cholestasis (PFIC) (initial requests): 1) diagnosis of PFIC has been confirmed by genetic testing, 2) the patient does not have PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3), AND 3) the patient does not have any other concomitant liver disease. For treatment of pruritis in PFIC (continuation requests): the patient has experienced benefit from therapy (for example, improvement in pruritis). For treatment of cholestatic pruritus with Alagille Syndrome (ALGS) (initial requests): 1) diagnosis of ALGS has been confirmed by genetic testing, AND 2) the patient does not have any other concomitant liver disease. For treatment of cholestatic pruritus with Alagille Syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	For PFIC: 3 months of age or older, For ALGS: 12 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BYNFEZIA
Drug Names	BYNFEZIA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	BYOOVIZ
Drug Names	BYOOVIZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	BYSANTI
Drug Names	BYSANTI, BYSANTI TITRATION PACK A, BYSANTI TITRATION PACK B, BYSANTI TITRATION PACK C
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of schizophrenia: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Cobenfy, Lybalvi, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Vraylar.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CABLIVI
Drug Names	CABLIVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acquired thrombotic thrombocytopenic purpura (aTTP): Patient has not experienced more than 2 recurrences of aTTP while on the requested drug. For aTTP (initial): 1) the request is for treatment during the plasma exchange period and/or directly following the completion of plasma exchange (PE), 2) patient will receive or has received the requested drug with PE, 3) the requested drug will be given in combination with immunosuppressive therapy, AND 4) patient will not receive the requested drug beyond 30 days from the cessation of PE unless the patient has documented persistent aTTP. For aTTP (continuation): 1) the request is for extension of therapy after the initial course of the requested drug (initial course: treatment with the requested drug during and 30 days after plasma exchange), 2) patient has documented signs of persistent underlying aTTP (example: severely reduced ADAMTS13 activity levels [less than 10%]), 3) the requested drug will be given in combination with immunosuppressive therapy, AND 4) patient has not received a prior 28 day extension of therapy after the initial course of the requested drug for this course of treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 60 days, Continuation: 28 days
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma, soft tissue sarcoma (alveolar soft part sarcoma and extraskeletal myxoid chondrosarcoma subtypes)
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV (including brain metastases). For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent therapy. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, oncocytic): 1) the disease is locally advanced or metastatic, AND 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI. For endometrial carcinoma: 1) the disease is recurrent, AND 2) the requested drug will be used as subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CALCIPOTRIENE
Drug Names	CALCIPOTRIENE, CALCIPOTRIENE/BETAMETHASO, CALCITRENE, ENSTILAR, PELLIX, SORILUX, TACLONEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	CALCITRIOL
Drug Names	CALCITRIOL, VECTICAL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	-
Required Medical Information	For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CAMBIA
Drug Names	CAMBIA, DICLOFENAC POTASSIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to diclofenac or any components of the requested drug. History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). The requested drug will be used in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	For acute treatment of migraine attacks with or without aura: 1) The patient has experienced an inadequate treatment response or intolerance to at least ONE of the following non-steroidal anti-inflammatory drugs (NSAIDs): a) ibuprofen, b) flurbiprofen, c) ketoprofen, d) naproxen AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CAMCEVI
Drug Names	CAMCEVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Salivary gland tumors
Exclusion Criteria	-
Required Medical Information	For all indications: the patient has experienced an intolerance to either leuprolide acetate solution OR triptorelin due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug. For salivary gland tumors: 1) the disease is androgen receptor positive, AND 2) the disease is recurrent, metastatic, or unresectable.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CAMZYOS
Drug Names	CAMZYOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For obstructive hypertrophic cardiomyopathy: 1) before initiating therapy, patient has left ventricular ejection fraction (LVEF) of 55 percent or greater, AND 2) patient has New York Heart Association (NYHA) class II-III symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinomas (follicular, oncocytic, papillary).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU, CARGLUMIC ACID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: Diagnosis confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CAVHANZA
Drug Names	CAVHANZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations, AND 3) The patient meets one of the following: a) The patient has had a trial of generic formulation nilotinib hydrochloride or has an intolerance to generic nilotinib hydrochloride, OR b) The patient has difficulty swallowing solid oral dosage forms (e.g., capsules), OR c) The patient is on concurrent therapy with a proton pump inhibitor (PPI) and/or a histamine type 2-receptor antagonist (H2RA).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CEQUA
Drug Names	CEQUA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to Restasis (cyclosporine 0.05 percent emulsion) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CEQUR
Drug Names	CEQUR SIMPLICITY 1U EXTND, CEQUR SIMPLICITY 2U, CEQUR SIMPLICITY 2U EXTND, CEQUR SIMPLICITY EXTENDED, CEQUR SIMPLICITY INSERTER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Initial: 1) the patient has diabetes requiring insulin management AND 2) the patient is currently self-testing glucose levels, the patient will be counseled on self-testing glucose levels, or the patient is using a continuous glucose monitor AND 3) the patient meets either of the following: a) the patient has tried bolus injections and either did not meet glycemic goals or had difficulties administering multiple insulin injections daily, b) the patient is unable to try bolus injections.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CERDELGA
Drug Names	CERDELGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Type 2 Gaucher disease, Type 3 Gaucher disease
Exclusion Criteria	-
Required Medical Information	For Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CHLORDIAZEPOXIDE
Drug Names	CHLORDIAZEPOXIDE HCL, CHLORDIAZEPOXIDE HYDROCHL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: 1) the prescriber must acknowledge the benefit of therapy with the prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), AND 2) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. For the management of anxiety disorders: 1) the requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), or b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-preop apprehens and anx-1 mo, Anxiety Disorder-4 mo, Alc Withdrawal-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	CHOLBAM
Drug Names	CHOLBAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For bile acid synthesis disorders due to single enzyme defects (SEDs) and adjunctive treatment of peroxisomal disorders (PDs): Diagnosis was confirmed by mass spectrometry or other biochemical or genetic testing. For bile acid synthesis disorders due to SEDs and adjunctive treatment of PDs, continuation of therapy: Patient has achieved and maintained improvement in liver function.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CIBINQO
Drug Names	CIBINQO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis (new starts only): 1) Patient has refractory, moderate to severe disease, AND 2) Patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): Patient achieved or maintained positive clinical response.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CIMERLI
Drug Names	CIMERLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	CIMZIA
Drug Names	CIMZIA, CIMZIA (1 SYRINGE), CIMZIA (2 SYRINGE), CIMZIA STARTER KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce), OR 2) the patient is currently pregnant and/or breastfeeding. For moderately to severely active rheumatoid arthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding. For active ankylosing spondylitis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding. For active non-radiographic axial spondyloarthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib) OR 2) the patient is currently pregnant and/or breastfeeding.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient meets either of the following: a) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce), OR b) the patient is currently pregnant and/or breastfeeding. For active psoriatic arthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx),

	Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce), OR 2) the patient is currently pregnant and/or breastfeeding. For active polyarticular juvenile idiopathic arthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding.
Prerequisite Therapy Required	Yes
Prior Authorization Group	CINQAIR
Drug Names	CINQAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma, initial therapy: 1) Either a) patient has baseline blood eosinophil count of at least 400 cells per microliter OR b) patient is dependent on systemic corticosteroids, AND 2) patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CLEMASTINE
Drug Names	CLEMASTINE FUMARATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one other formulary product such as levocetirizine solution or cetirizine solution. If the patient is 65 years of age or older, the prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CLOBAZAM
Drug Names	CLOBAZAM, ONFI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CLOMIPRAMINE
Drug Names	ANAFRANIL, CLOMIPRAMINE HYDROCHLORID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Depression, panic disorder
Exclusion Criteria	-
Required Medical Information	For obsessive-compulsive disorder (OCD) and panic disorder: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI). For depression: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. . For all indications: If the patient is 65 years of age or older AND is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient(Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.] For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	COLUMVI
Drug Names	COLUMVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Histological transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, HIV-related B-cell lymphoma, primary effusion lymphoma, HHV8-positive diffuse large B-cell lymphoma, monomorphic posttransplant lymphoproliferative disorder.
Exclusion Criteria	-
Required Medical Information	For histological transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, HIV-related B-cell lymphoma, primary effusion lymphoma, HHV8-positive diffuse large B-cell lymphoma, and monomorphic post-transplant lymphoproliferative disorder: at least two lines of systemic therapy have been utilized.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), thyroid carcinomas (follicular, oncocytic, papillary).
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): Disease is positive for rearranged during transfection (RET) rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	COPIKTRA
Drug Names	COPIKTRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma
Exclusion Criteria	-
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CORTROPHIN
Drug Names	CORTROPHIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the following diagnoses, patient has experienced an inadequate treatment response to a parenteral or an oral glucocorticoid (for ophthalmic diseases only, inadequate response to a trial of a topical ophthalmic glucocorticoid is also acceptable): 1) For rheumatic disorders (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, acute gouty arthritis): The requested drug must be used as adjunctive treatment, 2) For nephrotic syndrome: the requested drug must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic diseases (e.g., severe erythema multiforme, Stevens-Johnson syndrome, severe psoriasis), 6) Ophthalmic diseases, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Allergic states (e.g., serum sickness, atopic dermatitis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	MS exacerbation: 3 weeks, Allergic states: 1 month, All other diagnoses: 3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	COSENTYX
Drug Names	COSENTYX, COSENTYX SENSOREADY PEN, COSENTYX UNOREADY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce). For active ankylosing spondylitis (new starts only): Adult patients have experienced an inadequate treatment response, intolerance, or have a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib). For an adult with active psoriatic arthritis (PsA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Sotyktu (deucravacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For moderate to severe hidradenitis suppurativa (new starts only): Adult patients have experienced an inadequate treatment response, intolerance, or have a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Hadlima (adalimumab-bwwd), Humira (adalimumab).
Prerequisite Therapy Required	Yes

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Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Central nervous system (CNS) cancer (i.e., glioma, glioblastoma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma.
Exclusion Criteria	-
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, glioblastoma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CRENESSITY
Drug Names	CRENESSITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For congenital adrenal hyperplasia (CAH), initial: 1) Patient has a confirmed diagnosis of CAH by any of the following: a) genetic testing to confirm the presence of pathogenic variants in CYP21A1, b) confirmed 21-hydroxylase deficiency (e.g., cosyntropin [ACTH] stimulation test, baseline morning serum 17-hydroxyprogesterone [17-OHP] measurement by liquid chromatography-tandem mass spectrometry), AND 2) Patient is currently on supraphysiological glucocorticoid therapy.
Age Restrictions	4 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CRESEMBA
Drug Names	CRESEMBA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Fluconazole-refractory esophageal candidiasis in a patient with HIV, fungal peritoneal dialysis-associated peritonitis
Exclusion Criteria	-
Required Medical Information	The requested drug is being used orally. For invasive aspergillosis and fluconazole-refractory esophageal candidiasis in a patient with HIV: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to voriconazole.
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Invasive Aspergillosis: 3 mo. Invasive Mucormycosis: 6 mo. Esophageal candidiasis, peritonitis: 1 mo
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CRESEMBA INJ
Drug Names	CRESEMBA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Fungal peritoneal dialysis-associated peritonitis
Exclusion Criteria	-
Required Medical Information	The requested drug is being used orally by nasogastric (NG) tube administration or intravenously. For invasive aspergillosis: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to voriconazole.
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Invasive Aspergillosis: 3 months. Invasive Mucormycosis: 6 months. Peritonitis: 1 month
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CRINONE
Drug Names	CRINONE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prophylaxis for premature birth in women with a short cervix
Exclusion Criteria	Prescribed to promote fertility
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CROTAN
Drug Names	CROTAN, PRURADIK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pediculosis capitis (head lice)
Exclusion Criteria	-
Required Medical Information	For the eradication of scabies (Sarcoptes scabiei): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to permethrin 5 percent cream.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	CRYSVITA
Drug Names	CRYSVITA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CUTAQUIG
Drug Names	CUTAQUIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	CUVITRU
Drug Names	CUVITRU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	CUVRIOR
Drug Names	CUVRIOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CYRAMZA
Drug Names	CYRAMZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Esophageal adenocarcinoma, recurrent non-small cell lung cancer (NSCLC), appendiceal adenocarcinoma, pleural mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, thymomas and thymic carcinomas
Exclusion Criteria	-
Required Medical Information	For colorectal cancer and appendiceal adenocarcinoma: patient has advanced or metastatic disease. For NSCLC: patient has recurrent, advanced, or metastatic disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CYSTADROPS
Drug Names	CYSTADROPS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DALFAMPRIDINE
Drug Names	AMPYRA, DALFAMPRIDINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple sclerosis (for new starts): prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis (continuation): patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DANZITEN
Drug Names	DANZITEN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), pigmented villonodular synovitis/tenosynovial giant cell tumor
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DARAPRIM
Drug Names	DARAPRIM, PYRIMETHAMINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia prophylaxis, cystoisosporiasis treatment and secondary prophylaxis
Exclusion Criteria	-
Required Medical Information	For primary toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia (PCP) prophylaxis, and secondary cystoisosporiasis prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) AND 2) The patient is immunocompromised. For secondary toxoplasmosis prophylaxis: The patient is immunocompromised. For cystoisosporiasis treatment: The patient has experienced an intolerance or has a contraindication to TMP-SMX.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Congen toxo tx: Plan Yr. Acqu toxo tx, prim toxo ppx, PCP ppx: 3mo. Sec toxo ppx, cysto tx/ppx: 6mo
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DARZALEX
Drug Names	DARZALEX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, T-cell acute lymphoblastic leukemia
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DARZALEX FASPRO
Drug Names	DARZALEX FASPRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DATROWAY
Drug Names	DATROWAY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DAURISMO
Drug Names	DAURISMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Post-induction therapy/consolidation following response to previous therapy with the same regimen for acute myeloid leukemia (AML)
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy or post-induction/consolidation therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DAWNZERA
Drug Names	DAWNZERA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DAXXIFY
Drug Names	DAXXIFY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Cosmetic use
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DAYBUE
Drug Names	DAYBUE, DAYBUE STIX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DEFERASIROX
Drug Names	DEFERASIROX, EXJADE, JADENU, JADENU SPRINKLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DEFEROXAMINE
Drug Names	DEFEROXAMINE MESYLATE, DESFERAL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Aluminum toxicity in patients undergoing dialysis
Exclusion Criteria	-
Required Medical Information	For chronic iron overload: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	DEMSER
Drug Names	DEMSER, METYROSINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DESMODA
Drug Names	DESMODA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Diagnosis of central diabetes insipidus (also known as arginine vasopressin deficiency), AND 2) the patient meets either of the following: a) the patient has experienced an intolerable adverse event to one of the following products and that adverse event was NOT attributed to the active ingredient as described in the prescribing information: i) desmopressin tablets or ii) desmopressin nasal spray OR b) the patient has been unable to maintain normal serum sodium levels using desmopressin tablets or desmopressin nasal spray.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DEXMETHYLPHENIDATE
Drug Names	DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HYDROC, FOCALIN, FOCALIN XR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer-related fatigue
Exclusion Criteria	-
Required Medical Information	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DHE NASAL
Drug Names	DIHYDROERGOTAMINE MESYLAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 receptor agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DIACOMIT
Drug Names	DIACOMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	6 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM, DIAZEPAM INTENSOL, VALIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. Applies to greater than cumulative 5 days of therapy per year.
Prerequisite Therapy Required	Yes

Prior Authorization Group	DIBENZYLINE
Drug Names	PHENOXYBENZAMINE HYDROCHL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha 1 selective adrenergic receptor blocker (e.g., doxazosin).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	DICLOFENAC 2% SOL
Drug Names	DICLOFENAC SODIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For osteoarthritis of the knee(s): Patient has experienced an inadequate treatment response or intolerance to diclofenac sodium 1.5% topical solution.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DICLOFENAC 3% GEL
Drug Names	DICLOFENAC SODIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	DOJOLVI
Drug Names	DOJOLVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For long-chain fatty acid oxidation disorders (LC-FAOD): At least two of the following diagnostic criteria are met: a) disease-specific elevation of acylcarnitine (e.g., C16 and/or C18:1 for CPT2 deficiency, C16-OH and/or C18 and other acylcarnitines for LCHAD and TFP deficiency, C14:1 and/or other long-chain acylcarnitines for VLCAD deficiency) on a newborn blood spot or in plasma, b) low enzyme activity in cultured fibroblasts, c) confirmed pathogenic variant(s) in an LC-FAOD gene (e.g., CPT1A, SLC25A20, CPT2, ACADVL, HADHA, HADHB). For LC-FAOD, continuation of therapy: Patient is experiencing benefit from therapy (e.g., improvement in muscle symptoms and/or exercise tolerance).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DOPTELET
Drug Names	DOPTELET, DOPTELET SPRINKLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation): platelet count response to the requested drug: 1) Current platelet count is less than or equal to 200,000/mcL, OR 2) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	Chronic liver disease: 18 years of age or older, ITP: 1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Chronic liver disease: 1 month, ITP initial: 6 months, ITP continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DRIZALMA
Drug Names	DRIZALMA SPRINKLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer pain, chemotherapy-induced neuropathic pain
Exclusion Criteria	-
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. For Generalized Anxiety Disorder, Diabetic Peripheral Neuropathy, Fibromyalgia, Chronic Musculoskeletal pain: 1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration).
Age Restrictions	Generalized Anxiety Disorder: 7 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	DUOBRII
Drug Names	DUOBRII
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis: the patient experienced an inadequate treatment response or intolerance to a topical corticosteroid.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	DUPIXENT
Drug Names	DUPIXENT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For oral corticosteroid dependent asthma, initial therapy: Patient has inadequate asthma control despite current treatment with both of the following medications: 1) High-dose inhaled corticosteroid AND 2) Additional controller (i.e., long acting beta2-agonist (LABA), long-acting, muscarinic antagonist (LAMA), leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, initial therapy: Patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., LABA, LAMA, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	Atopic Dermatitis: 6 months of age or older, Chronic Spontaneous Urticaria: 2 years of age or older, Asthma and Allergic Fungal Rhinosinusitis: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis: 12 years of age or older, Chronic Obstructive Pulmonary Disease, Bullous Pemphigoid, and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 1 year of age or older
Prescriber Restrictions	-
Coverage Duration	AD, PN, CSU initial: 6 months, AD cont, PN cont, CSU cont, All others: Plan Year
Other Criteria	For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) For 18 years of age or older, patient has experienced an inadequate treatment response to Xhance (fluticasone). For eosinophilic esophagitis (EoE), initial therapy: 1) Diagnosis has been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field, AND 2) Patient is exhibiting clinical manifestations of the disease (for example, dysphagia), AND 3) Patient weighs at least 15 kilograms, AND 4) Patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid. For chronic obstructive pulmonary disease (COPD), initial therapy: 1) Patient is either of the following: a) currently receiving standard inhaled triple therapy (i.e., inhaled glucocorticoid, LAMA, and LABA) or b) currently receiving a LAMA and LABA, and has a contraindication to inhaled glucocorticoid, AND 2) Patient has an absolute blood

	eosinophil count of at least 300 cells per microliter prior to initiating therapy. For chronic spontaneous urticaria (CSU), initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), AND 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Patient remains symptomatic despite H1 antihistamine treatment. For CSU, continuation of therapy: Patient has experienced a benefit (e.g., improved symptoms) since initiation of therapy. For bullous pemphigoid (BP), initial therapy: 1) Diagnosis has been confirmed by direct immunofluorescence study OR immune serological test(s), AND 2) Patient exhibits clinical manifestations of the disease (e.g., bullous lesions, excoriations, eczematous and/or urticarial erythematous lesions), AND 3) Prior to initiation with the requested drug the patient has had an inadequate treatment response to either a high-potency topical corticosteroid or systemic corticosteroid OR high-potency topical corticosteroids and systemic corticosteroids are not advisable for the patient. For allergic fungal rhinosinusitis (AFRS), initial therapy: 1) Patient has a history of sino-nasal surgery AND 2) The diagnosis of AFRS was confirmed by all of the following: a) Patient has confirmed Type 1 fungal hypersensitivity, b) Patient has a history of nasal polyps, c) CT scans show sinus opacification, d) Surgically obtained eosinophilic mucin is positive for the presence of noninvasive fungi. For AD, EoE, PN, COPD, BP, AFRS, continuation of therapy: Patient achieved or maintained a positive clinical response.
Prerequisite Therapy Required	Yes
Prior Authorization Group	DUVYZAT
Drug Names	DUVYZAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of Duchenne muscular dystrophy (DMD): The diagnosis was confirmed by genetic testing identifying a disease-causing mutation of the DMD gene.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	DYSPORT
Drug Names	DYSPORT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Blepharospasm
Exclusion Criteria	Cosmetic use
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EBGLYSS
Drug Names	EBGLYSS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis, initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has experienced an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For atopic dermatitis, continuation of therapy: Patient achieved or maintained positive clinical response.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EGRIFTA
Drug Names	EGRIFTA SV, EGRIFTA WR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use for weight loss
Required Medical Information	For human immunodeficiency virus (HIV)-infected patients with lipodystrophy: Patient is receiving anti-retroviral therapy. For patients who have received at least 6 months of the requested drug: Patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference measurement or computed tomography (CT) scan.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or endocrinologist
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EKTERLY
Drug Names	EKTERLY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) The patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) The patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) The patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) The patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ELAHERE
Drug Names	ELAHERE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ELAPRASE
Drug Names	ELAPRASE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis II (MPS II): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase (IDS) enzyme activity or by genetic testing.
Age Restrictions	16 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ELELYSO
Drug Names	ELELYSO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ELFABRIO
Drug Names	ELFABRIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Fabry disease, the patient meets ANY of the following: 1) Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) The patient is a symptomatic obligate carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ELIGARD
Drug Names	ELIGARD
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Salivary gland tumors
Exclusion Criteria	-
Required Medical Information	For salivary gland tumors: 1) the disease is androgen receptor positive AND 2) the disease is recurrent, metastatic, or unresectable.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ELYXYB
Drug Names	ELYXYB
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to celecoxib or any components of the requested drug. History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). Allergic-type reactions to sulfonamides. The requested drug will be used in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to at least ONE of the following non-steroidal anti-inflammatory drugs (NSAIDs): a) ibuprofen, b) flurbiprofen, c) ketoprofen, d) naproxen AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EMGALITY
Drug Names	EMGALITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. For episodic cluster headache, initial: The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan 5-HT1 receptor agonist. For episodic cluster headache, continuation: The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EMPAVELI
Drug Names	EMPAVELI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient has demonstrated a positive response to therapy. For complement 3 glomerulopathy (C3G) and primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN): 1) For initial: the diagnosis of C3G or IC-MPGN is confirmed by kidney biopsy, AND 2) The patient meets any of the following: a) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) OR b) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	PNH Initial: 6 months, PNH continuation, All others: Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	EMPLICITI
Drug Names	EMPLICITI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EMRELIS
Drug Names	EMRELIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EMROSI
Drug Names	EMROSI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) The patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) The patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EMSAM
Drug Names	EMSAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Major Depressive Disorder (MDD): 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion, OR 2) The patient is unable to swallow oral formulations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ENDARI
Drug Names	ENDARI, L-GLUTAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	5 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ENHERTU
Drug Names	ENHERTU
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), recurrent, locally advanced, or metastatic HER2-positive esophageal adenocarcinoma, recurrent HER2-positive gastric or esophagogastric junction adenocarcinoma, palliative therapy for HER2 overexpression positive esophageal, gastric or esophagogastric junction adenocarcinoma, brain metastases in patients with HER2-positive breast cancer, HER2 positive recurrent salivary gland tumors, recurrent or stage IVB HER2-positive cervical cancer, advanced, recurrent, or metastatic HER2-positive vulvar cancer, Recurrent HER2-positive endometrial carcinoma, recurrent or platinum resistant persistent HER2-positive ovarian cancer/fallopian tube cancer/peritoneal cancer, HER2-positive vaginal cancer, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), recurrent or metastatic HER2-positive bladder cancer, HER2-amplified small bowel adenocarcinoma, HER2-positive occult cancer, locally advanced or metastatic HER2-positive pancreatic adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	For ovarian cancer, fallopian tube cancer, or peritoneal cancer: the patient's disease is both of the following: A) the patient's disease is recurrent or platinum resistant AND B) the patient's disease is HER2-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	ENJAYMO
Drug Names	ENJAYMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cold agglutinin disease (continuation): patient achieved or maintained a positive clinical response (e.g., improvement in hemoglobin levels, markers of hemolysis [e.g., bilirubin, haptoglobin, lactate dehydrogenase [LDH], reticulocyte count], and a reduction in blood transfusions).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ENSACOVE
Drug Names	ENSACOVE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) The patient has recurrent, advanced, or metastatic disease, AND 2) The disease is anaplastic lymphoma kinase (ALK)-positive, AND 3) The patient has not previously received an ALK-inhibitor, OR the patient has experienced intolerance or disease progression with crizotinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ENSPRYNG
Drug Names	ENSPRYNG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For neuromyelitis optica spectrum disorder (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) the patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EOHILIA
Drug Names	EOHILIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For eosinophilic esophagitis (EoE): 1) Diagnosis has been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field, AND 2) The patient is exhibiting clinical manifestations of the disease (for example, dysphagia).
Age Restrictions	11 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, allergist, or immunologist
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	EPKINLY
Drug Names	EPKINLY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Histological transformation of follicular or marginal zone lymphoma to diffuse large B-cell lymphoma, Primary effusion lymphoma, HIV-related diffuse B-cell lymphoma, HHV8-positive diffuse large B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (PTLD).
Exclusion Criteria	-
Required Medical Information	For histological transformation of follicular or marginal zone lymphoma to diffuse large B-cell lymphoma, Primary effusion lymphoma, HIV-related diffuse B-cell lymphoma, HHV8-positive diffuse large B-cell lymphoma, and monomorphic post-transplant lymphoproliferative disorder (PTLD): at least two lines of systemic therapy have been utilized.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	EPOGEN
Drug Names	EPOGEN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Anemia with CKD, zidovudine: Plan Year, All others: 16 weeks
Other Criteria	Coverage includes use in anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs). Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prerequisite Therapy Required	No

Prior Authorization Group	EPRONTIA
Drug Names	EPRONTIA, TOPIRAMATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has tried a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has tried a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	Epilepsy: 2 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EPSOLAY
Drug Names	EPSOLAY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EPYSQLI
Drug Names	EPYSQLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient (pt) has demonstrated a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels). For atypical hemolytic uremic syndrome (aHUS) (initial): The disease is not caused by Shiga toxin-producing Escherichia coli. For aHUS (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The pt has demonstrated a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts). For generalized myasthenia gravis (continuation): 1) There is no evidence of unacceptable toxicity while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy. For neuromyelitis optica spectrum disorder (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ERGOTAMINE
Drug Names	CAFERGOT, ERGOMAR, ERGOTAMINE TARTRATE/CAFFE, MIGERGOT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult medulloblastoma
Exclusion Criteria	-
Required Medical Information	For adult medulloblastoma: patient has received prior systemic therapy AND has tumor(s) with mutations in the sonic hedgehog pathway.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ERLEADA
Drug Names	ERLEADA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ERLOTINIB
Drug Names	ERLOTINIB HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ESBRIET
Drug Names	ESBRIET, PIRFENIDONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ETANERCEPT
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hidradenitis suppurativa, non-radiographic axial spondyloarthritis
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) The patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EUCRISA
Drug Names	EUCRISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the patient is 2 years of age or older and the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the patient is 2 years of age or older and the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	3 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EURAX
Drug Names	EURAX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pediculosis capitis (head lice)
Exclusion Criteria	-
Required Medical Information	For the eradication of scabies (Sarcoptes scabiei): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to permethrin 5 percent cream.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	Yes

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

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Prior Authorization Group	EVEROLIMUS
Drug Names	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS, TORPENZ, YULITHIRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, oncocytic, and follicular), endometrial carcinoma, uterine sarcoma, breast cancer (in combination with fulvestrant or tamoxifen), histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis), meningiomas.
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: 1) The disease is residual, recurrent, unresectable, or metastatic/tumor rupture, AND 2) The disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EVKEEZA
Drug Names	EVKEEZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initiation of therapy (tx) to treat homozygous familial hypercholesterolemia (HoFH), patient (pt) must meet ALL of the following: A) Diagnosis of HoFH confirmed by one of the following: 1) Genetic testing to confirm two mutant alleles at low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus OR 2) History of an untreated low-density lipoprotein-cholesterol (LDL-C) greater than 400 mg/dL and either of the following: a) Presence of cutaneous or tendinous xanthomas before the age of 10 years, or b) An untreated LDL-C level greater than or equal to 190 mg/dL in both parents, which is consistent with heterozygous familial hypercholesterolemia (HeFH), AND B) If the pt is 7 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a high-intensity statin at a maximally tolerated dose or at the maximum dose approved by the Food and Drug Administration (FDA) unless the pt is statin intolerant or has a contraindication to statin tx, AND C) If the pt is 10 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a PCSK9-directed tx at a maximally tolerated dose or at the maximum dose approved by the FDA unless the pt has experienced an intolerance or has a contraindication to all PCSK9-directed therapies, AND D) Prior to initiation of treatment, pt is/was experiencing an inadequate response to lipid-lowering tx as indicated by a treated LDL-C greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease), AND E) Pt will continue to receive concomitant lipid lowering tx. For renewal of tx to treat HoFH: A) Pt meets all initial criteria, AND B) Has responded to tx as demonstrated by a reduction in LDL-C from baseline, AND C) Is receiving concomitant lipid lowering tx.
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EVRYSDI
Drug Names	EVRYSDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For spinal muscular atrophy (SMA) initial therapy, patient meets ALL of the following: 1) Patient has type 1, type 2, or type 3 SMA, AND 2) Patient is not dependent on permanent ventilation. For SMA continuation of therapy, patient meets ALL of the following: 1) Patient has type 1, type 2, or type 3 SMA, AND 2) Patient has experienced functional improvement or maintenance of muscle function.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in spinal muscular atrophy
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	EXELDERM CREAM
Drug Names	EXELDERM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to both of the following: 1) clotrimazole cream AND 2) ketoconazole cream or shampoo.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EXELDERM SOL
Drug Names	EXELDERM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to both of the following: 1) clotrimazole cream AND 2) ketoconazole cream or shampoo.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EXXUA
Drug Names	EXXUA, EXXUA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	EYLEA
Drug Names	EYLEA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	EYLEA HD
Drug Names	EYLEA HD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

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Prior Authorization Group	FABHALTA
Drug Names	FABHALTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs), AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The patient (pt) has demonstrated a positive response to therapy. To slow kidney function decline in pts with primary immunoglobulin A nephropathy (IgAN) at risk of disease progression: 1) The pt had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]), OR 2) The pt experienced an intolerance or has a contraindication to RAS inhibitors. For complement 3 glomerulopathy (C3G): 1) For initial, the diagnosis of C3G is confirmed by kidney biopsy, AND 2) The pt meets any of the following: A) The pt had an inadequate response to therapy with a maximally tolerated dose of a RAS inhibitor (e.g., ACE inhibitor or ARB), OR B) The pt experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	PNH Initial: 6 months, PNH Continuation: Plan Year, Other indications: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FABIOR
Drug Names	FABIOR, TAZAROTENE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Fabry disease, the patient meets ANY of the following: 1) Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) The patient is a symptomatic obligate carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FANAPT
Drug Names	FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of schizophrenia: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Caplyta, Cobenfy, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Vraylar.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FASENRA
Drug Names	FASENRA, FASENRA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, AND 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, OR 3) no active vasculitis. For hypereosinophilic syndrome (HES), initial therapy: 1) Patient has HES without an identifiable non-hematologic secondary cause, AND 2) Patient does not have FIP1L1-PDGFRA kinase-positive HES, AND 3) Patient has a history or presence of a blood eosinophil count of at least 1000 cells per microliter, AND 4) Patient has been on at least one HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy). For HES, continuation of therapy: Patient has experienced a beneficial response to treatment as demonstrated by a reduction in HES flares.
Age Restrictions	Asthma: 6 years of age or older, HES: 12 years of age or older, EGPA: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FEBUXOSTAT
Drug Names	FEBUXOSTAT, ULORIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FENSOLVI
Drug Names	FENSOLVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FERRIPROX
Drug Names	DEFERIPRONE, FERRIPROX, FERRIPROX TWICE-A-DAY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient's transfusional iron overload is not due to myelodysplastic syndrome or Diamond Blackfan anemia.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	FETZIMA
Drug Names	FETZIMA, FETZIMA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FILKRI
Drug Names	FILKRI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FILSPARI
Drug Names	FILSPARI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For patients with primary immunoglobulin A nephropathy (IgAN) at risk of disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]), OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors. For focal segmental glomerulosclerosis (FSGS): 1) The diagnosis of FSGS is confirmed by kidney biopsy or presence of pathogenic variant in a podocyte protein associated with FSGS, AND 2) The patient does not have nephrotic syndrome, AND 3) The requested medication will be used for the reduction of proteinuria.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FILSUVEZ
Drug Names	FILSUVEZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will not be administered to wound(s) that are currently healed.
Age Restrictions	6 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or wound care specialist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FINACEA
Drug Names	FINACEA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FINTEPLA
Drug Names	FINTEPLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FIRDAPSE
Drug Names	FIRDAPSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	History of seizures
Required Medical Information	-
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FIRMAGON
Drug Names	FIRMAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FLEQSUVY
Drug Names	BACLOFEN, FLEQSUVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient is unable to take oral solid dosage forms for any reason (e.g., difficulty swallowing tablets or capsules, requires administration via feeding tube).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FLUCYTOSINE
Drug Names	ANCOBON, FLUCYTOSINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	fungal peritoneal dialysis-associated peritonitis
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Peritonitis: 1 month, Candida: 6 weeks, Cryptococcus: 6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FLUTICASONE-SALMETEROL
Drug Names	ADVAIR DISKUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of asthma and maintenance treatment of chronic obstructive pulmonary disease (COPD): the patient has experienced an intolerance to a preferred fluticasone-salmeterol product due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FOLOTYN
Drug Names	FOLOTYN, PRALATREXATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome, adult T-cell leukemia/lymphoma (ATLL), extranodal natural killer (NK)/T-cell lymphoma, hepatosplenic T-cell lymphoma, cutaneous anaplastic large cell lymphoma, initial palliative intent therapy for peripheral T-cell lymphoma, breast implant-associated anaplastic large cell lymphoma (BIA-ALCL).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FORM ALT PA AMLODIPINE
Drug Names	SDAMLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA CLINDAMYCIN
Drug Names	CLINDAGEL, CLINDAMYCIN PHOSPHATE (ON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one of the following formulary products: clindamycin lotion, clindamycin topical solution, clindamycin gel (twice daily).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA DICLOFENAC
Drug Names	DICLOFENAC POTASSIUM, LOFENA, ZIPSOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA DIFLUSINAL
Drug Names	DOLOBID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	FORM ALT PA DOXYCYCLINE
Drug Names	DORYX MPC, DOXYCYCLINE HYCLATE DR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product such as doxycycline monohydrate or doxycycline hyclate tablets or capsules (excludes delayed release formulations).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA FENOPROFEN
Drug Names	FENOPROFEN CALCIUM, FENOPRON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA GABARONE
Drug Names	GABARONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	FORM ALT PA MELOXICAM
Drug Names	MELOXICAM, ZYBIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA MUPIROCIN
Drug Names	MUPIROCIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA NAPROXEN
Drug Names	NAPRELAN, NAPROXEN, NAPROXEN SODIUM ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA NITROFURANTOIN SUSP
Drug Names	NITROFURANTOIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA OXYCODONE-APAP
Drug Names	NALOCET, OXYCODONE AND ACETAMINOPH, OXYCODONE HYDROCHLORIDE/A, OXYCODONE/ACETAMINOPHEN, PERCOCET, PROLATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA SPRIX
Drug Names	SPRIX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	FORM ALT PA TOLMETIN
Drug Names	TOLECTIN 600, TOLMETIN SODIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA TOPICAL ACYCLOVIR
Drug Names	ACYCLOVIR, ZOVIRAX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA TOPICAL KETOCONAZOLE
Drug Names	KETOCONAZOLE, KETODAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA TOPICAL STEROIDS
Drug Names	AMCINONIDE, BRYHALI, CLOCORTOLONE PIVALATE, CORDRAN, DESONIDE, DESOXIMETASONE, DIFLORASONE DIACETATE, EVESSE, FLURANDRENOLIDE, HALCINONIDE, HALOBETASOL PROPIONATE, HALOG, HYDROCORTISONE BUTYRATE, LEXETTE, TOPICORT, TRIAMCINOLONE ACETONIDE, ULTRAVATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance to two other formulary topical steroids.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA TRAMADOL
Drug Names	TRAMADOL HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to one other formulary product.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORM ALT PA TRAMADOL SOL
Drug Names	TRAMADOL HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has experienced an intolerance, caused by an inactive ingredient, to one other formulary product such as tramadol tablets, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	FORM ALT PA VALSARTAN SOL
Drug Names	VALSARTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has experienced an intolerance, caused by an inactive ingredient, to one other formulary product such as valsartan tablets, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FORTEO
Drug Names	FORTEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For glucocorticoid-induced osteoporosis: patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 24 months, Continuation: Plan Year
Other Criteria	Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Patient has high FRAX fracture probability if the 10-year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.
Prerequisite Therapy Required	Yes

Prior Authorization Group	FOTIVDA
Drug Names	FOTIVDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: 1) The disease is advanced, relapsed, refractory or Stage IV, AND 2) The patient has received two or more prior systemic therapies.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FRUZAQLA
Drug Names	FRUZAQLA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Appendiceal adenocarcinoma
Exclusion Criteria	-
Required Medical Information	For colorectal cancer and appendiceal adenocarcinoma: 1) the disease is advanced or metastatic, AND 2) the requested drug will be used as a single agent, AND 3) the requested drug will be used as a second line or subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FULPHILA
Drug Names	FULPHILA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FYARRO
Drug Names	FYARRO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent or inoperable uterine sarcoma with perivascular epithelioid cell tumor (PEComa) histology
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA, PERAMPANEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam.
Age Restrictions	Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	FYLNETRA
Drug Names	FYLNETRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GALAFOLD
Drug Names	GALAFOLD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GATTEX
Drug Names	GATTEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short bowel syndrome (SBS) initial therapy: the patient is dependent on parenteral support. For SBS continuation: requirement for parenteral support has decreased from baseline while on therapy with the requested drug.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	GAVRETO
Drug Names	GAVRETO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer, RET gene fusion positive gallbladder cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
Age Restrictions	Non-small cell lung cancer: 18 years of age or older, Thyroid cancer: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GAZYVA
Drug Names	GAZYVA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Small lymphocytic lymphoma (SLL), extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites (noncutaneous), nodal marginal zone lymphoma, splenic marginal zone lymphoma, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas, Burkitt lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, Castleman disease, hairy cell leukemia
Exclusion Criteria	-
Required Medical Information	For all indications except lupus nephritis (LN): the disease is CD20-positive. For extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites (noncutaneous), nodal marginal zone lymphoma, and splenic marginal zone lymphoma: the requested drug is used in any of the following settings: 1) second-line or subsequent therapy, or 2) maintenance therapy, or 3) a substitute for rituximab in a patient who has experienced an intolerance or rare complication (e.g., mucocutaneous reaction) to rituximab, or 4) first-line therapy (nodal marginal zone lymphoma indication only). For histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas, Burkitt lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, and Castleman disease: the patient has experienced an intolerance or rare complication (e.g., mucocutaneous reaction) to rituximab. For LN: 1) patient is currently receiving a standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis, AND 3) for initial starts, patient has confirmed diagnosis of LN from either of the following: a) kidney biopsy, b) positive for antibodies relevant to systemic lupus erythematosus (SLE) (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins).
Age Restrictions	Lupus nephritis: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	GILENYA
Drug Names	FINGOLIMOD HYDROCHLORIDE, GILENYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For epidermal growth factor receptor (EGFR)-positive non-small cell lung cancer (NSCLC): 1) The disease is recurrent, advanced, or metastatic, AND 2) The patient has experienced an intolerable adverse event or contraindication to erlotinib, gefitinib, or osimertinib. For metastatic squamous NSCLC: The disease has progressed after platinum-based chemotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	GIMOTI
Drug Names	GIMOTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient will not use metoclopramide for more than 12 consecutive weeks of therapy, AND 2) The patient has experienced an inadequate treatment response or intolerance to oral metoclopramide OR The patient is unable to take oral metoclopramide.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	GIVLAARI
Drug Names	GIVLAARI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GLATIRAMER
Drug Names	COPAXONE, GLATIRAMER ACETATE, GLATOPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GOCOVRI
Drug Names	GOCOVRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	GOMEKLI
Drug Names	GOMEKLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GONADOTROPIN
Drug Names	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL W/DILUENT BENZYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Induction of ovulation
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GRALISE
Drug Names	GABAPENTIN ONCE-DAILY, GRALISE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postherpetic neuralgia: The patient has experienced an inadequate treatment response or intolerance to generic gabapentin immediate-release.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	GRANIX
Drug Names	GRANIX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation related indications, following chemotherapy for acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), neutropenia in myelodysplastic syndrome (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia, patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GRASTEK
Drug Names	GRASTEK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	-
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, NORDITROPIN FLEXPRO, OMNITROPE, ZOMACTON
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist
Coverage Duration	Plan Year
Other Criteria	Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. For pediatric GHD, TS, SGA, and adult GHD, continuation of therapy: Patient is experiencing improvement.
Prerequisite Therapy Required	No

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Prior Authorization Group	HADLIMA
Drug Names	ADALIMUMAB-BWWD, HADLIMA, HADLIMA PUSHTOUCH
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-radiographic axial spondyloarthritis, Behcet's disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HAEGARDA
Drug Names	HAEGARDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HARVONI
Drug Names	HARVONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HEMADY
Drug Names	HEMADY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HEPCLUDEX
Drug Names	HEPCLUDEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis delta virus (HDV) infection (initial): The patient meets all of the following: 1) The diagnosis of HDV infection was confirmed by: a) positive serologic testing for HDV antibodies, AND b) positive molecular testing for HDV-RNA (hepatitis delta virus-ribonucleic acid), AND 2) The HDV infection has been present for greater than 6 months, AND 3) The patient has an elevated pretreatment alanine transaminase (ALT) level, AND 4) The patient does not have decompensated cirrhosis or prior/active hepatic decompensation events (e.g., variceal hemorrhage, ascites, hepatic encephalopathy). For chronic hepatitis delta virus (HDV) infection (continuation): The patient has experienced a beneficial response to therapy (e.g., decrease in HDV-RNA levels from baseline and improvement of ALT (alanine transaminase) levels from baseline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HERCEPTIN HYLECTA
Drug Names	HERCEPTIN HYLECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	HERCESSI
Drug Names	HERCESSI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	HERNEXEOS
Drug Names	HERNEXEOS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) The disease is positive for human epidermal growth factor receptor 2 (HER2) (erythroblastic oncogene B [ERBB2]) mutations AND 2) The disease is recurrent, advanced, unresectable, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HERZUMA
Drug Names	HERZUMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ, TASIMELTEON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy, the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS, AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	Non-24: 18 years of age or older, SMS: 16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HETLIOZ LQ
Drug Names	HETLIOZ LQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS, AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	3 to 15 years of age
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	HIGH RISK MEDICATION
Drug Names	CORPHENA, DIPYRIDAMOLE, KETOROLAC TROMETHAMINE, METHSCOPOLAMINE BROMIDE, METHYLDOPA, RYCLORA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	No

Prior Authorization Group	HIZENTRA
Drug Names	HIZENTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	HORIZANT
Drug Names	HORIZANT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Restless Legs Syndrome: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one of the following generic products: pramipexole immediate-release OR ropinirole immediate-release. For postherpetic neuralgia: The patient has experienced an inadequate treatment response or intolerance to generic gabapentin immediate-release.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-AMITRIPTYLINE
Drug Names	AMITRIPTYLINE HYDROCHLORI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neuropathic pain, chronic tension-type headache prophylaxis, chronic neck pain
Exclusion Criteria	-
Required Medical Information	For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-ANTICONVULSANTS
Drug Names	PHENOBARBITAL, PHENOBARBITAL SODIUM
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Epilepsy
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	No

Prior Authorization Group	HRM-ANTIPARKINSON
Drug Names	BENZTROPINE MESYLATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine OR 3) The patient has tried the non-HRM alternative drug amantadine AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-CARBINOXAMINE
Drug Names	CARBINOXAMINE MALEATE, CARBINOXAMINE MALEATE ER, CARBZAH, KARBINAL ER, RYVENT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-CLEMASTINE
Drug Names	CLEMASTINE FUMARATE, CLEMSZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-CYPROHEPTADINE
Drug Names	CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pruritus, spasticity due to spinal cord injury
Exclusion Criteria	-
Required Medical Information	For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior Authorization applies to greater than cumulative 30 days of therapy per year.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	HRM-DOXEPIN
Drug Names	DOXEPIN HCL, DOXEPIN HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-GUANFACINE ER
Drug Names	GUANFACINE HYDROCHLORIDE, INTUNIV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	No

Prior Authorization Group	HRM-GUANFACINE IR
Drug Names	GUANFACINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	No

Prior Authorization Group	HRM-HYDROXYZINE
Drug Names	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-HYDROXYZINE INJ
Drug Names	HYDROXYZINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam OR 3) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-HYPNOTICS
Drug Names	AMBIEN, AMBIEN CR, EDLUAR, ESZOPICLONE, LUNESTA, ZALEPLON, ZOLPIDEM TARTRATE, ZOLPIDEM TARTRATE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For insomnia: 1) The patient meets one of the following: a) the patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drugs doxepin (3 mg or 6 mg) and ramelteon OR b) The patient has tried one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND the patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	HRM-MECLIZINE
Drug Names	MECLIZINE HCL, MECLIZINE HYDROCHLORIDE
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 30 days of therapy per year.
Prerequisite Therapy Required	No

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Prior Authorization Group	HRM-PROMETHAZINE
Drug Names	PHENERGAN, PROMETHAZINE HCL, PROMETHAZINE HYDROCHLORID, PROMETHEGAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HRM-SKELETAL MUSCLE RELAXANTS
Drug Names	ATMEKSI, CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, FEXMID, METAXALONE, METHOCARBAMOL, SOMA, TANLOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 2) If the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.
Prerequisite Therapy Required	No

Prior Authorization Group	HRM-TCA NEUROPATHIC PAIN
Drug Names	DESIPRAMINE HYDROCHLORIDE, IMIPRAMINE HCL, IMIPRAMINE HYDROCHLORIDE, IMIPRAMINE PAMOATE, NORPRAMIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neuropathic pain
Exclusion Criteria	-
Required Medical Information	For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
Prerequisite Therapy Required	Yes

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-radiographic axial spondyloarthritis, Behcet's disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HYFTOR
Drug Names	HYFTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	HYPNOTIC BENZODIAZEPINES
Drug Names	ESTAZOLAM, TRIAZOLAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg) or ramelteon, AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]..
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. Applies to greater than cumulative 90 days of therapy per year.
Prerequisite Therapy Required	Yes

Prior Authorization Group	HYQVIA
Drug Names	HYQVIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	HYRNUO
Drug Names	HYRNUO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer: 1) The disease is positive for human epidermal growth factor receptor 2 (HER2) (erythroblastic oncogene B [ERBB2]) mutations, AND 2) The disease is recurrent, advanced, or metastatic, AND 3) The requested drug will be used as subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) the disease is advanced, recurrent, or metastatic, AND 2) the patient has hormone receptor (HR)-positive disease, AND 3) one of the following: a) the disease is human epidermal growth factor receptor 2 (HER2)-negative and the patient meets ONE of the following: i) the requested drug will be used in combination with an aromatase inhibitor or fulvestrant, AND the patient has experienced an intolerable adverse event or has a contraindication to Kisqali (ribociclib) or Verzenio (abemaciclib), OR ii) the patient is endocrine-resistant, PIK3CA-mutated, AND the requested drug will be used in combination with inavolisib and fulvestrant, OR b) the disease is HER2 positive and the requested drug will be used in combination with trastuzumab and endocrine therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IBSRELA
Drug Names	IBSRELA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IBTROZI
Drug Names	IBTROZI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IBUPROFEN-FAMOTIDINE
Drug Names	IBUPROFEN/FAMOTIDINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to two different regimens containing any combination of a nonsteroidal anti-inflammatory drug (NSAID) and an acid blocker from any of the following drug classes: H2-receptor antagonist (H2RA), proton pump inhibitor (PPI).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ICATIBANT
Drug Names	FIRAZYR, ICATIBANT ACETATE, SAJAZIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase, Gastrointestinal Stromal Tumors
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Patient has accelerated or blast phase CML and no other kinase inhibitor is indicated, OR 2) Patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib, dasatinib, or nilotinib, OR 3) Patient is positive for the T315I mutation, OR 4) Patient has no identifiable BCR-ABL1 mutation and resistance to primary therapy with imatinib, bosutinib, dasatinib, or nilotinib. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For gastrointestinal stromal tumors (GIST): 1) Disease meets any of the following: A) residual, B) unresectable, C) recurrent, D) metastatic/tumor rupture, AND 2) Disease has progressed after use of at least two Food and Drug Administration (FDA) approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IDHIFA
Drug Names	IDHIFA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Newly-diagnosed acute myeloid leukemia
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient has newly-diagnosed AML and is not a candidate for or declines intensive induction therapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) the requested drug will be used as consolidation therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ILARIS
Drug Names	ILARIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For active systemic juvenile idiopathic arthritis or active adult-onset Still's disease (new starts only), patient must meet either of the following criteria: 1) inadequate response to a nonsteroidal anti-inflammatory drug (NSAID), a corticosteroid, methotrexate, or leflunomide, OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For gout flares, patient must meet all of the following (new starts): 1) two or more gout flares within the previous 12 months prior to the initial treatment with the requested drug, AND 2) inadequate response, intolerance, or contraindication to at least two of the following: non-steroidal anti-inflammatory drugs (NSAIDs), colchicine, or corticosteroids. For gout flares (continuation): patient experienced a positive clinical response from treatment with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ILUMYA
Drug Names	ILUMYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IMAAVY
Drug Names	IMAAVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For generalized myasthenia gravis (gMG), continuation: 1) There is no evidence of unacceptable toxicity while on the current regimen AND 2) Patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	IMATINIB
Drug Names	GLEEVEC, IMATINIB MESYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, cutaneous melanoma, Kaposi sarcoma, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFRA fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma), brain metastases in lymphoma
Exclusion Criteria	-
Required Medical Information	For mantle cell lymphoma: 1) the requested drug will be used as subsequent therapy OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma: The requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed or refractory disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IMDELLTRA
Drug Names	IMDELLTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IMFINZI
Drug Names	IMFINZI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable stage II non-small cell lung cancer (NSCLC), recurrent NSCLC, single agent maintenance for extensive stage small cell lung cancer following combination treatment with etoposide and carboplatin, persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), ampullary adenocarcinoma, gastric cancer, esophageal and esophagogastric junction cancers, pleural mesothelioma.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is unresectable Stage II or III OR 2) the disease is resectable, recurrent, advanced, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IMJUDO
Drug Names	IMJUDO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), gastric cancer, esophageal and esophagogastric junction cancers.
Exclusion Criteria	-
Required Medical Information	For the treatment of non-small cell lung cancer (NSCLC): the disease is recurrent, advanced, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IMKELDI
Drug Names	IMKELDI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent chordoma, cutaneous melanoma, Kaposi sarcoma
Exclusion Criteria	-
Required Medical Information	For all indications: The patient is unable to use imatinib tablets. For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IMVEXXY
Drug Names	IMVEXXY MAINTENANCE PACK, IMVEXXY STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INBRIJA
Drug Names	INBRIJA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initial treatment of off episodes in Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa, AND 2) The patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease. For continuation treatment of off episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INFLECTRA
Drug Names	INFLECTRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. For all indications: The patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

Prior Authorization Group	INLURIYO
Drug Names	INLURIYO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INLYTA
Drug Names	INLYTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (papillary, oncocytic, or follicular), alveolar soft part sarcoma
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: the disease is advanced, relapsed, or Stage IV.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INQOVI
Drug Names	INQOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INREBIC
Drug Names	INREBIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	-
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INSULIN SUPPLIES
Drug Names	-
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested product is being used with insulin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	INTRAROSA
Drug Names	INTRAROSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	IQIRVO
Drug Names	IQIRVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary biliary cholangitis (PBC): For initial therapy: 1) Diagnosis of PBC is confirmed by at least two of the following: a) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, b) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (e.g., anti-gp210, anti-sp100), c) Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts), AND 2) Patient has an elevated serum ALP level prior to initiation of therapy with the requested drug and meets one of the following requirements: a) Has experienced an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the patient will continue concomitant therapy with UDCA/ursodiol, b) Is intolerant to prior therapy with UDCA/ursodiol. For PBC (continuation): Patient achieved or maintained a clinical benefit from Iqirvo therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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

Prior Authorization Group	IRESSA
Drug Names	GEFITINIB, IRESSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ISOTRETINOIN
Drug Names	ABSORICA, ABSORICA LD, ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, ZENATANE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Severe acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ISTURISA
Drug Names	ISTURISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ITOVEBI
Drug Names	ITOVEBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For breast cancer, the patient meets all of the following: a) the disease is recurrent, locally advanced, or metastatic, b) the disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and PIK3CA-mutated, c) the requested drug will be used in combination with fulvestrant and palbociclib, d) the patient has experienced disease progression, relapse, or recurrence on or after completing adjuvant endocrine therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	IVERMECTIN TAB
Drug Names	IVERMECTIN, STROMECTOL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
Exclusion Criteria	-
Required Medical Information	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IVIG
Drug Names	ALYGLO, BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN, QIVIGY, YIMMUGO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	IWILFIN
Drug Names	IWILFIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	IZERVAY
Drug Names	IZERVAY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI, JAKAFI XR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Lower-risk myelofibrosis, accelerated or blast phase myeloproliferative neoplasms, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement, T-cell prolymphocytic leukemia, T-cell large granular lymphocytic leukemia
Exclusion Criteria	-
Required Medical Information	For polycythemia vera: 1) patient has an inadequate response, intolerance, or resistance to hydroxyurea AND 2) patient meets ONE of the following: a) patient has an inadequate response or intolerance to Besremi (ropeginterferon alfa-2b-njft), OR b) patient has high risk disease. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	JASCAYD
Drug Names	JASCAYD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (IPF) (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to nintedanib or pirfenidone. For progressive pulmonary fibrosis (PPF) (new starts only): 1) the patient has confirmed progressive disease (e.g., forced vital capacity [FVC] decline, worsening respiratory symptoms, increased extent of fibrosis on high resolution computed tomography [HRCT]), AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to nintedanib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	JATENZO
Drug Names	JATENZO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	JAYPIRCA
Drug Names	JAYPIRCA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	-
Required Medical Information	For chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): The patient has received prior treatment with a Bruton Tyrosine Kinase (BTK) inhibitor, for example Calquence (acalabrutinib) or Brukinsa (zanubrutinib). For mantle cell lymphoma: the patient has received prior treatment with a BTK inhibitor, for example Calquence (acalabrutinib) or Brukinsa (zanubrutinib). For marginal zone lymphoma (MZL): the patient has received a covalent Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib) or Brukinsa (zanubrutinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	JEMPERLI
Drug Names	JEMPERLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For colorectal cancer and small bowel adenocarcinoma: the patient has mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) disease or polymerase epsilon-delta (POLE/POLD1) mutated disease. For solid tumors: the patient has mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	JEVTANA
Drug Names	JEVTANA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	JIDEYTRO
Drug Names	JIDEYTRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	JOBEVNE
Drug Names	JOBEVNE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	JOENJA
Drug Names	JOENJA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For activated phosphoinositide 3-kinase delta syndrome (APDS): the diagnosis was confirmed by genetic testing demonstrating variant in either PIK3CD or PIK3R1.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	JOURNAVX
Drug Names	JOURNAVX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	JUXTAPID
Drug Names	JUXTAPID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initiation of therapy (tx) to treat homozygous familial hypercholesterolemia (HoFH), patient (pt) must meet ALL of the following: A) Diagnosis of HoFH confirmed by one of the following: 1) Genetic testing to confirm two mutant alleles at low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus OR 2) History of an untreated low-density lipoprotein-cholesterol (LDL-C) greater than 400 mg/dL and either of the following: a) Presence of cutaneous or tendinous xanthomas before the age of 10 years, or b) An untreated LDL-C level greater than or equal to 190 mg/dL in both parents, which is consistent with heterozygous familial hypercholesterolemia (HeFH), AND B) If the pt is 7 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a high-intensity statin at a maximally tolerated dose or at the maximum dose approved by the Food and Drug Administration (FDA) unless the pt is statin intolerant or has a contraindication to statin tx, AND C) If the pt is 10 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a PCSK9-directed tx at a maximally tolerated dose or at the maximum dose approved by the FDA unless the pt has experienced an intolerance or has a contraindication to all PCSK9-directed therapies, AND D) Prior to initiation of treatment, pt is/was experiencing an inadequate response to lipid-lowering tx as indicated by a treated LDL-C greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease), AND E) Pt will continue to receive concomitant lipid lowering tx. For renewal of tx to treat HoFH: A) Pt meets all initial criteria, AND B) Has responded to tx as demonstrated by a reduction in LDL-C from baseline, AND C) Is receiving concomitant lipid lowering tx.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	JYNARQUE
Drug Names	JYNARQUE, TOLVAPTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KALBITOR
Drug Names	KALBITOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).
Age Restrictions	1 month of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KANJINTI
Drug Names	KANJINTI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	KANUMA
Drug Names	KANUMA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For lysosomal acid lipase deficiency: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of lysosomal acid lipase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KESIMPTA
Drug Names	KESIMPTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KETOCONAZOLE
Drug Names	KETOCONAZOLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cushing's syndrome
Exclusion Criteria	Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine.
Required Medical Information	The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KETOPROFEN
Drug Names	KETOPROFEN, KETOPROFEN ER, ORUDIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For a Food and Drug Administration (FDA)-approved indication: The patient has experienced an inadequate treatment response or intolerance to two oral nonsteroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KEVEYIS
Drug Names	DICHLORPHENAMIDE, KEVEYIS, ORMALVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary HYPOkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hypokalemic periodic paralysis, OR 3) Patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out. For primary HYPERkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hyperkalemic periodic paralysis, OR 3) Patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out. For continuation of therapy for primary HYPOkalemic and primary HYPERkalemic periodic paralysis: Patient is demonstrating a response to therapy with the requested drug as demonstrated by a decrease in the number or severity of attacks.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months. Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KEVZARA
Drug Names	KEVZARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For polymyalgia rheumatica (PMR) (new starts only): 1) Patient has experienced an inadequate treatment response to corticosteroids OR 2) Patient has experienced a disease flare while attempting to taper corticosteroids OR 3) Patient has a contraindication that would prohibit a trial of corticosteroids. For active polyarticular juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KEYTRUDA
Drug Names	KEYTRUDA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KEYTRUDA QLEX
Drug Names	KEYTRUDA QLEX
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KHINDIVI
Drug Names	KHINDIVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For adrenocortical insufficiency: 1) Patient requires a strength that is not available in hydrocortisone tablets OR 2) Patient has difficulty swallowing hydrocortisone tablets.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KIMMTRAK
Drug Names	KIMMTRAK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KINERET
Drug Names	KINERET
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic juvenile idiopathic arthritis, adult-onset Still's disease, multicentric Castleman's disease, Schnitzler syndrome, Erdheim-Chester disease.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib-extended release). For active systemic juvenile idiopathic arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Tyenne (tocilizumab-aazg).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KISQALI
Drug Names	KISQALI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant. Endometrial cancer, in combination with letrozole, for estrogen receptor positive tumors
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KLISYRI
Drug Names	KLISYRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KOMZIFTI
Drug Names	KOMZIFTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KONVOMEP
Drug Names	KONVOMEP
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of active benign gastric ulcer: 1) The patient has experienced an inadequate treatment response to a one-month trial each of two proton pump inhibitors (PPIs), OR 2) The patient has experienced an intolerance, or the patient has a contraindication that would prohibit a one-month trial of two proton pump inhibitors (PPIs), AND 3) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KORLYM
Drug Names	KORLYM, MIFEPRISTONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KOSELUGO
Drug Names	KOSELUGO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive circumscribed glioma, Langerhans cell histiocytosis
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	For neurofibromatosis type 1: 1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KRAZATI
Drug Names	KRAZATI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), Central nervous system (CNS) brain metastases from KRAS G12C-positive NSCLC, KRAS G12C-positive pancreatic adenocarcinoma, KRAS G12C-positive ampullary adenocarcinoma, KRAS G12C-positive appendiceal adenocarcinoma, KRAS G12C-positive Biliary Tract Cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, gall bladder cancer)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KRISTALOSE
Drug Names	KRISTALOSE, LACTULOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For constipation: 1) The patient has had a one month trial of generic lactulose solution, OR 2) The patient has experienced an intolerance that would prohibit a one month trial of generic lactulose solution, OR 3) The patient has a contraindication to an inactive ingredient in generic lactulose solution which is not contained in the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	KRYSTEXXA
Drug Names	KRYSTEXXA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will not be used concomitantly with oral urate-lowering agents. For initiation of therapy for chronic gout: 1) the patient must meet either of the following: a) patient has had an inadequate response to a 3-month trial of a xanthine oxidase inhibitor at the maximum medically appropriate dose unless there is a clinical reason for not completing a trial (e.g., severe allergic reaction, toxicity, intolerance, significant drug interaction, severe renal dysfunction [for allopurinol only], end stage renal impairment [for febuxostat only], or history of cardiovascular disease (CVD) or a new cardiovascular (CV) event [for febuxostat only]), or b) if there is a clinical reason for not completing a 3-month trial with a xanthine oxidase inhibitor, an inadequate response to a 3-month trial of probenecid is required unless there is a clinical reason for not completing a trial of probenecid (e.g., renal insufficiency [glomerular filtration rate of 30 mL per minute or less], severe allergic reaction, toxicity, intolerance, existing blood dyscrasias or uric acid kidney stones, and significant drug interaction) AND 2) the patient experiences frequent gout flares (greater than or equal to 2 per year) OR the patient has at least 1 gout tophus or gouty arthritis. For continuation of therapy for treatment of chronic gout: 1) patient has not had 2 consecutive uric acid levels above 6 mg/dL, AND 2) patient is experiencing benefit from therapy (e.g., serum uric acid levels less than 6 mg/dL, reduction of tophi, reduction of symptoms and/or flares).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	KYPROLIS
Drug Names	KYPROLIS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma, systemic light chain amyloidosis
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	KYZATREX
Drug Names	KYZATREX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LAMZEDE
Drug Names	LAMZEDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For non-central nervous system manifestations of alpha-mannosidosis: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-mannosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LAPATINIB
Drug Names	LAPATINIB DITOSYLATE, TYKERB
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma)
Exclusion Criteria	-
Required Medical Information	For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	LAZCLUZE
Drug Names	LAZCLUZE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LEMTRADA
Drug Names	LEMTRADA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, active secondary progressive MS), the patient meets ALL of the following: 1) For first treatment course, patient has experienced an inadequate response to two or more drugs indicated for MS despite adequate duration of treatment, AND 2) For second and subsequent treatment courses, treatment will start at least 12 months after the last dose of the prior treatment course.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	30 days
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LENVIMA
Drug Names	LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma, unresectable or metastatic cutaneous melanoma.
Exclusion Criteria	-
Required Medical Information	For differentiated thyroid cancer (follicular, papillary, or oncocytic): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma (HCC): disease is unresectable, extrahepatic/metastatic, or liver-confined. For renal cell carcinoma (RCC): the disease is advanced, relapsed, or stage IV. For endometrial carcinoma (EC), the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy. For anaplastic thyroid carcinoma, the patient meets ALL of the following: 1) The disease is metastatic, 2) The requested drug will be used in combination with pembrolizumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LEQEMBI
Drug Names	LEQEMBI IQLIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will not be used in combination with any other monoclonal antibody directed against amyloid beta. For Alzheimer's disease (new starts only): 1) other causes of cognitive impairment or dementia have been excluded, AND 2) diagnosis was confirmed by the presence of beta amyloid pathology on positron emission tomography (PET) scan or by cerebrospinal fluid (CSF) biomarker testing, AND 3) disease is classified as mild cognitive impairment or mild dementia stage, AND 4) patient has had a baseline brain magnetic resonance imaging (MRI) prior to initiation of therapy with the requested drug to evaluate for pre-existing amyloid related imaging abnormalities (ARIA), and will be monitored for the development of ARIA. For Alzheimer's disease (continuation of therapy): 1) patient has experienced a beneficial response to therapy, AND 2) patient has been evaluated for evidence of ARIA on MRI.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LEQSELVI
Drug Names	LEQSELVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe alopecia areata (initial): 1) Patient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) AND 2) Patient does not have primarily diffuse pattern alopecia (characterized by diffuse hair shedding) or other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss). For severe alopecia areata (continuation): Patient has achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	LEUKERAN
Drug Names	LEUKERAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LEUKINE
Drug Names	LEUKINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prophylaxis of chemotherapy-induced febrile neutropenia (FN), neutropenia in myelodysplastic syndromes (MDS), neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, severe chronic neutropenia (congenital, cyclic, or idiopathic), neuroblastoma
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of chemotherapy-induced febrile neutropenia (FN), the patient must meet both of the following: 1) Patient has a non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LEUPROLIDE
Drug Names	LEUPROLIDE ACETATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LIBTAYO
Drug Names	LIBTAYO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer, cervical cancer, vulvar cancer, vaginal cancer, small bowel adenocarcinoma, anal carcinoma, colon cancer, appendiceal adenocarcinoma, rectal cancer.
Exclusion Criteria	-
Required Medical Information	For basal cell carcinoma: the patient was previously treated with a hedgehog pathway inhibitor OR treatment with a hedgehog pathway inhibitor is not appropriate. For non-small cell lung cancer (NSCLC): the disease is advanced, recurrent, or metastatic. For cervical cancer, vaginal cancer, vulvar cancer, and anal carcinoma: the requested drug will be used as second-line or subsequent therapy. For colon cancer, appendiceal adenocarcinoma, and rectal cancer: the disease is deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LIDOCAINE PATCHES
Drug Names	LIDOCAINE, LIDOCAN, TRIDACAINE III, ZTLIDO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LIFYORLI
Drug Names	LIFYORLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	LITFULO
Drug Names	LITFULO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe alopecia areata (initial): 1) Patient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT), AND 2) Patient does not have primarily diffuse pattern alopecia (characterized by diffuse hair shedding) or other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss). For severe alopecia areata (continuation): Patient has achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LIVDELZI
Drug Names	LIVDELZI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary biliary cholangitis (PBC): For initial therapy: 1) Diagnosis of PBC is confirmed by at least two of the following: a) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, b) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (e.g., anti-gp210, anti-sp100), c) Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts), AND 2) Patient has an elevated serum ALP level prior to initiation of therapy with the requested drug and meets one of the following requirements: a) Has experienced an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the patient will continue concomitant therapy with UDCA/ursodiol, b) Is intolerant to prior therapy with UDCA/ursodiol. For PBC (continuation): Patient achieved or maintained a clinical benefit from Livdelzi therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LIVMARLI
Drug Names	LIVMARLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of cholestatic pruritis in a patient with Alagille syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis). For treatment of cholestatic pruritis in a patient with Progressive Familial Intrahepatic Cholestasis (PFIC), (initial): 1) diagnosis of PFIC has been confirmed by genetic testing, 2) the patient does not have PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein, AND 3) the patient does not have any other concomitant liver disease. For treatment of cholestatic pruritis in a patient with PFIC (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	For ALGS: 3 months of age or older, For PFIC: 12 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LIVTENCITY
Drug Names	LIVTENCITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LOARGYS
Drug Names	LOARGYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Arginase 1 Deficiency (ARG1-D): The diagnosis was confirmed by one of the following: 1) genetic testing demonstrating biallelic pathogenic variants in the ARG1 gene, OR 2) enzyme assay demonstrating a deficiency of arginase enzyme activity (i.e., less than 1% of normal) in erythrocytes.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of enzyme or metabolic disorders
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LODOCO
Drug Names	LODOCO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LONSURF
Drug Names	LONSURF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable locally advanced, recurrent, or metastatic esophageal cancer. Unresectable locally advanced or recurrent gastric cancer and gastroesophageal junction cancers. Advanced or metastatic appendiceal adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): The disease is advanced or metastatic. For gastric, esophageal, or gastroesophageal junction adenocarcinoma, ALL of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LOQTORZI
Drug Names	LOQTORZI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable nasopharyngeal carcinoma (NPC) in combination with cisplatin and gemcitabine
Exclusion Criteria	-
Required Medical Information	For the treatment of nasopharyngeal carcinoma (NPC): 1) the requested drug will be used in combination with cisplatin and gemcitabine AND the disease is unresectable, metastatic, locally advanced, or recurrent, OR 2) patient meets ALL of the following: a) the requested drug will be used as a single agent, AND b) the disease is recurrent, unresectable, or metastatic, AND c) the patient has experienced disease progression on or after a platinum-containing chemotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LORBRENA
Drug Names	LORBRENA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC), proto-oncogene tyrosine-protein kinase ROS1 (ROS1) rearrangement-positive recurrent, advanced, or metastatic NSCLC, symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), central nervous system (CNS) brain metastases from ALK rearrangement-positive NSCLC, relapsed or refractory ALK-positive Diffuse Large B-Cell Lymphoma, relapsed or refractory ALK-positive Peripheral T-Cell Lymphoma
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic non-small cell lung cancer: 1) Disease is ALK-positive, OR 2) Disease is positive for ROS1 rearrangement and the requested drug is being used following disease progression on one of the following: crizotinib, entrectinib, ceritinib, or repotrectinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LOREEV
Drug Names	LOREEV XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For anxiety disorder: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety disorder, OR the patient experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs), AND 2) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored), AND 3) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	LUCEMYRA
Drug Names	LOFEXIDINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUCENTIS
Drug Names	LUCENTIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	LUMAKRAS
Drug Names	LUMAKRAS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), recurrent, locally advanced, or metastatic KRAS G12C-positive pancreatic adenocarcinoma, advanced or unresectable KRAS G12C-positive colorectal cancer (including appendiceal adenocarcinoma), progressive KRAS G12C-positive ampullary adenocarcinoma
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has KRAS G12C mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUMRYZ
Drug Names	LUMRYZ, LUMRYZ STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. For continuation of therapy: The patient has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LUMVOA
Drug Names	LUMVOA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Thyroid Eye Disease: The patient has not previously received 5 or more infusions of the requested drug.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist
Coverage Duration	4 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	LUNSUMIO
Drug Names	LUNSUMIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUNSUMIO VELO
Drug Names	LUNSUMIO VELO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUPKYNIS
Drug Names	LUPKYNIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use in combination with cyclophosphamide
Required Medical Information	For lupus nephritis (LN): 1) patient is currently receiving background immunosuppressive therapy regimen for lupus nephritis (for example, mycophenolate mofetil, corticosteroids), OR 2) patient has an intolerance or has a contraindication to background immunosuppressive therapy regimen for lupus nephritis, AND 3) for initial starts, patient has confirmed diagnosis of LN from either of the following: a) kidney biopsy, b) positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). For lupus nephritis continuation: patient is receiving benefit from therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUPRON PED
Drug Names	LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH, LUPRON DEPOT-PED (6-MONTH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUPRON-ENDOMETRIOSIS
Drug Names	LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH)
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, androgen receptor positive recurrent salivary gland tumor
Exclusion Criteria	-
Required Medical Information	For retreatment of endometriosis, the requested drug is used in combination with norethindrone acetate. For uterine fibroids, patient must meet one of the following: 1) diagnosis of anemia (for example, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LUPRON-PROSTATE CA
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH), LUTRATE DEPOT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	malignant sex cord-stromal tumors
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LYNAVOY
Drug Names	LYNAVOY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cholestatic pruritus associated with primary biliary cholangitis (PBC): For initial therapy: 1) Patient has a confirmed diagnosis of PBC by at least two of the following: a) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, b) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (e.g., anti-gp210, anti-sp100), c) Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts), AND 2) Patient does not have decompensated cirrhosis or prior/active hepatic decompensation events (e.g., variceal hemorrhage, ascites, hepatic encephalopathy). For cholestatic pruritus associated with PBC (continuation of therapy): Patient has experienced a beneficial response to therapy (e.g., reduced itching, improved pruritus-related sleep interference).
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	LYNKUET
Drug Names	LYNKUET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LYNOZYFIC
Drug Names	LYNOZYFIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma.
Exclusion Criteria	-
Required Medical Information	For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: 1) The patient has a BRCA mutation and the requested drug will be used in combination with abiraterone and an oral corticosteroid OR 2) The patient has progressed on prior treatment with an androgen receptor-directed therapy. For ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the patient has had at least one prior therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LYRICA CR
Drug Names	LYRICA CR, PREGABALIN ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For neuropathic pain associated with diabetic peripheral neuropathy (DPN) and postherpetic neuralgia (PHN): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to generic gabapentin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	LYTGOBI
Drug Names	LYTGOBI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Extrahepatic cholangiocarcinoma
Exclusion Criteria	-
Required Medical Information	For cholangiocarcinoma: 1) patient has a diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma, 2) the requested drug is being used as subsequent therapy, AND 3) patient has a disease that has a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MARGENZA
Drug Names	MARGENZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MAVENCLAD
Drug Names	CLADRIBINE, MAVENCLAD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	60 days
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MAVYRET
Drug Names	MAVYRET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MAYZENT
Drug Names	MAYZENT, MAYZENT STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer-related cachexia in adults
Exclusion Criteria	-
Required Medical Information	Patient has experienced an inadequate treatment response or intolerance to megestrol 40 milligrams per milliliter (40mg/mL) oral suspension.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease, hairy cell leukemia.
Exclusion Criteria	-
Required Medical Information	For melanoma: 1) The tumor is positive for a BRAF mutation, AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib. For hairy cell leukemia: 1) the requested drug will be used in combination with dabrafenib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	MEKTOVI
Drug Names	MEKTOVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis, recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with encorafenib, AND 3) The disease is advanced, recurrent, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MEMANTINE
Drug Names	MEMANTINE HCL TITRATION P, MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This prior authorization only applies to patients less than 30 years of age.
Prerequisite Therapy Required	No

Prior Authorization Group	MEPRON
Drug Names	ATOVAQUONE, MEPRON
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Babesiosis, Toxoplasmosis, Pneumocystis jirovecii pneumonia prophylaxis in pediatric patients, mild-to-moderate Pneumocystis jirovecii pneumonia treatment in pediatric patients
Exclusion Criteria	-
Required Medical Information	For the treatment of mild-to-moderate Pneumocystis jiroveci pneumonia (PCP): the patient had an intolerance or has a contraindication to sulfamethoxazole/trimethoprim (SMX-TMP). For the prevention of PCP and primary toxoplasmosis prophylaxis indications: 1) the patient had an intolerance or has a contraindication to SMX-TMP, AND 2) the patient is immunocompromised. For secondary toxoplasmosis prophylaxis: the patient is immunocompromised. For babesiosis treatment: the requested drug is used concurrently with azithromycin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Toxoplasmosis prophylaxis, PCP prophylaxis: 6 months, All other indications: 3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	METFORMIN ER
Drug Names	METFORMIN HYDROCHLORIDE E
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerance that prohibited a 4-week trial of metformin immediate-release AND generic Glucophage XR.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	METHERGINE
Drug Names	METHERGINE, METHYLERGONOVINE MALEATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	METHYLPHENIDATE
Drug Names	CONCERTA, COTEMPLA XR-ODT, DAYTRANA, JORNAY PM, METADATE CD, METHYLIN, METHYLPHENIDATE, METHYLPHENIDATE ER ODT, METHYLPHENIDATE HYDROCHLO, QUILLICHEW ER, QUILLIVANT XR, RELEXXII, RITALIN
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study OR 3) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MICO-ZN-PETR OINT
Drug Names	MICONAZOLE NITRATE/ZINC O, VUSION
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The presence of candidal infection has been confirmed by microscopic evaluation (microscopic evidence of pseudohyphae and/or budding yeast) prior to initiating treatment.
Age Restrictions	Pediatric patient 4 weeks of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MIGLUSTAT
Drug Names	MIGLUSTAT, YARGESA, ZAVESCA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease (GD1): The diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MIPLYFFA
Drug Names	MIPLYFFA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Niemann-Pick disease type C, initial: 1) The diagnosis was confirmed by genetic testing demonstrating a variant of either the NPC1 or NPC2 gene, 2) The patient has neurological manifestations of disease (e.g., loss of fine motor skills, swallowing, speech, ambulation), AND 3) The requested medication will not be used in combination with Aqneursa (levacetylleucine), AND 4) The requested medication will be used in combination with miglustat. For Niemann-Pick disease type C, continuation: The patient is experiencing benefit from therapy (e.g., stabilization or improvement in fine motor skills, swallowing, speech, ambulation).
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MIRCERA
Drug Names	MIRCERA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval of anemia due to chronic kidney disease (CKD): 1) patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL. For reauthorizations (patient received erythropoietin treatment in previous month): 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prerequisite Therapy Required	Yes

Prior Authorization Group	MIRVASO
Drug Names	BRIMONIDINE TARTRATE, MIRVASO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL, PROVIGIL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Idiopathic hypersomnia
Exclusion Criteria	-
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device. For idiopathic hypersomnia, initial request, the diagnosis has been confirmed by ALL of the following: 1) Patient has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) Insufficient sleep syndrome is confirmed absent, AND 3) Cataplexy is absent, AND 4) Fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) Average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) Another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results. For idiopathic hypersomnia, continuation of therapy: The patient has experienced a decrease in daytime sleepiness from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MODEYSO
Drug Names	MODEYSO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MONJUVI
Drug Names	MONJUVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma
Exclusion Criteria	-
Required Medical Information	For diffuse large B-cell lymphoma (DLBCL) not otherwise specified, HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma, diffuse large B-cell lymphoma (DLBCL) not otherwise specified including DLBCL arising from low grade lymphoma: 1) the patient has relapsed or refractory disease, AND 2) the patient is not eligible for autologous stem cell transplant (ASCT).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MOTPOLY XR
Drug Names	MOTPOLY XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	MOUNJARO
Drug Names	MOUNJARO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MOZOBIL
Drug Names	MOZOBIL, PLERIXAFOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MRESVIA
Drug Names	MRESVIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MULPLETA
Drug Names	MULPLETA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MVASI
Drug Names	MVASI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	MYALEPT
Drug Names	MYALEPT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Human immunodeficiency virus (HIV) - related lipodystrophy. Generalized obesity not associated with generalized lipodystrophy.
Required Medical Information	For lipodystrophy, patient meets ALL of the following: 1) Patient has a diagnosis of congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome) OR acquired generalized lipodystrophy (i.e., Lawrence syndrome), 2) Patient has leptin deficiency confirmed by laboratory testing, AND 3) Patient has at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin levels). For lipodystrophy (renewal): Patient has experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MYCAPSSA
Drug Names	MYCAPSSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MYFEMBREE
Drug Names	MYFEMBREE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and moderate to severe pain associated with endometriosis in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months, max 24 months total
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MYLOTARG
Drug Names	MYLOTARG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute promyelocytic leukemia (APL)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MYOBLOC
Drug Names	MYOBLOC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Primary axillary hyperhidrosis, palmar hyperhidrosis
Exclusion Criteria	Cosmetic use
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	MYQORZO
Drug Names	MYQORZO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For obstructive hypertrophic cardiomyopathy: 1) before initiating therapy, patient has left ventricular ejection fraction (LVEF) of 55 percent or greater, AND 2) patient has New York Heart Association (NYHA) class II-III symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NAGLAZYME
Drug Names	NAGLAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome) was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NAPROXEN-ESOMEPRAZOLE
Drug Names	NAPROXEN/ESOMEPRAZOLE MAG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to two different regimens containing any combination of a nonsteroidal anti-inflammatory drug (NSAID) and an acid blocker from any of the following drug classes: H2-receptor antagonist (H2RA), proton pump inhibitor (PPI).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NEMLUVIO
Drug Names	NEMLUVIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For prurigo nodularis (PN), continuation of therapy: Patient achieved or maintained a positive clinical response. For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has experienced an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: Patient achieved or maintained positive clinical response.
Age Restrictions	PN: 18 years of age or older, AD: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NERLYNX
Drug Names	NERLYNX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NEULASTA
Drug Names	NEULASTA, NEULASTA ONPRO KIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NEUPOGEN
Drug Names	NEUPOGEN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	NEUPRO
Drug Names	NEUPRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Parkinson's disease and restless legs syndrome: 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one of the following generics: ropinirole, pramipexole OR 2) The patient is unable to swallow oral formulations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR, SORAFENIB TOSYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive and any of the following is met :1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is being used for low-intensity treatment induction, post-induction therapy, or consolidation therapy, OR 3) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, oncocytic, or medullary. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NEXVIAZYME
Drug Names	NEXVIAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For late-onset Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NGENLA
Drug Names	NGENLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For pediatric growth hormone deficiency (GHD), initial: A) Patient (pt) has pre-treatment (pre-tx) 1-year height (ht) velocity more than 2 standard deviations (SD) below mean OR a pre-tx ht more than 2 SD below mean and a 1-year ht velocity more than 1 SD below mean AND pt meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean OR B) Pt was diagnosed with GHD as a neonate. For pediatric GHD, continuation of therapy: Pt is experiencing improvement.
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NIKTIMVO
Drug Names	NIKTIMVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NILOTINIB
Drug Names	NILOTINIB D-TARTRATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor, cutaneous melanoma
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. For gastrointestinal stromal tumor (GIST): 1) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, AND 2) Disease has progressed on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g. imatinib, sunitinib, regorafenib, ripretinib). For cutaneous melanoma: 1) Disease is metastatic or unresectable, AND 2) Disease is positive for c-KIT activating mutations, AND 3) Requested drug will be used as subsequent therapy, AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NINLARO
Drug Names	NINLARO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NITISINONE
Drug Names	NITISINONE, ORFADIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine), 2) genetic testing (mutation analysis), 3) enzyme assay.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NITYR
Drug Names	NITYR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine), 2) genetic testing (mutation analysis), 3) enzyme assay.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NIVESTYM
Drug Names	NIVESTYM
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NORITATE
Drug Names	NORITATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NORTHERA
Drug Names	DROXIDOPA, NORTHERA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For neurogenic orthostatic hypotension (nOH): For initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy, patient has experienced a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NOXAFIL POWDER
Drug Names	NOXAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used orally. For treatment of invasive Aspergillosis, prophylaxis of invasive Aspergillus and Candida infections: patient weighs 40 kilograms or less.
Age Restrictions	2 to less than 18 years of age
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	NOXAFIL SUSP
Drug Names	NOXAFIL, POSACONAZOLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.
Age Restrictions	13 years of age or older
Prescriber Restrictions	-
Coverage Duration	Oropharyngeal candidiasis: 1 month. All other indications: 6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NPLATE
Drug Names	NPLATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For immune thrombocytopenia (ITP) (new starts): 1) Patient has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation): Patient has platelet count response to the requested drug with ONE of the following: 1) Current platelet count is less than or equal to 200,000/mcL OR 2) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL AND dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	For ITP: Initial: 6 months, Continuation: Plan Year, For HSARS: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	NUBEQA
Drug Names	NUBEQA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NUCALA
Drug Names	NUCALA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma, initial therapy: 1) Either a) patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) patient is dependent on systemic corticosteroids, AND 2) patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, OR 3) no active vasculitis. For hypereosinophilic syndrome (HES), initial therapy: 1) patient has had HES for greater than or equal to 6 months, 2) patient has HES without an identifiable non-hematologic secondary cause, 3) patient does not have FIP1L1-PDGFRA kinase-positive HES, 4) patient has a history or presence of a blood eosinophil count of at least 1000 cells per microliter, AND 5) patient has been on a stable dose of at least one HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy). For HES, continuation of therapy: patient has a beneficial response to treatment as demonstrated by a reduction in HES flares.
Age Restrictions	Asthma: 6 years of age or older, EGPA, CRSwNP, and COPD: 18 years of age or older, HES: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) the requested drug is used as add-on maintenance treatment, AND 2) the patient has experienced inadequate treatment response to Xhance (fluticasone). For chronic obstructive pulmonary disease (COPD), initial therapy: 1) Patient is either of the following: a) currently receiving standard inhaled triple therapy (i.e., inhaled glucocorticoid, LAMA, and LABA) or b) currently receiving a LAMA and LABA, and has a contraindication to inhaled glucocorticoid, AND 2) Patient has an absolute blood eosinophil count of at least 150 cells per microliter prior to initiating therapy. For COPD, continuation of therapy: Patient achieved or maintained a positive clinical response.
Prerequisite Therapy Required	Yes

Prior Authorization Group	NUEDEXTA
Drug Names	DEXTROMETHORPHAN HYDROBRO, NUEDEXTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pseudobulbar affect (PBA), initial: 1) The patient has a diagnosis of pseudobulbar affect due to underlying neurological disease or injury AND 2) the patient is experiencing PBA episodes characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. For PBA, continuation: The patient has experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 4 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	NURTEC
Drug Names	NURTEC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist. For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Preventive treatment of migraine, initial: 3 months, All other indications: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	NYPOZI
Drug Names	NYPOZI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	NYVEPRIA
Drug Names	NYVEPRIA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OCREVUS
Drug Names	OCREVUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OCREVUS ZUNOVO
Drug Names	OCREVUS ZUNOVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE, SANDOSTATIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tumor control of thymomas and thymic carcinomas
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ODACTRA
Drug Names	ODACTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	-
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ODOMZO
Drug Names	ODOMZO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	OFEV
Drug Names	NINTEDANIB ESYLATE, OFEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. For chronic fibrosing interstitial lung diseases with progressive phenotype (progressive pulmonary fibrosis): the patient has confirmed progressive disease (e.g., forced vital capacity [FVC] decline, worsening respiratory symptoms, increased extent of fibrosis on high resolution computed tomography [HRCT]). For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	OGIVRI
Drug Names	OGIVRI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	OGSIVEO
Drug Names	OGSIVEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OHTUVAYRE
Drug Names	OHTUVAYRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic obstructive pulmonary disease (COPD): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following: budesonide/formoterol, fluticasone/salmeterol, Breo Ellipta (fluticasone/vilanterol), Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone/umeclidinium/vilanterol).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	OJEMDA
Drug Names	OJEMDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For relapsed or refractory pediatric low-grade glioma (LGG): the patient's tumor is positive for either a) BRAF fusion or rearrangement OR b) BRAF V600 mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OJJAARA
Drug Names	OJJAARA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	-
Required Medical Information	For myelofibrosis, patient meets ALL of the following: 1) the patient has a diagnosis of intermediate or high-risk primary myelofibrosis or secondary myelofibrosis (i.e., post-polycythemia vera or post-essential thrombocythemia), AND 2) the patient has anemia defined as hemoglobin less than 10 grams per deciliter (g/dL) or having transfusion-dependent anemia, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Jakafi (ruxolitinib) OR has hemoglobin less than 8 g/dL.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OLUMIANT
Drug Names	OLUMIANT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For severe alopecia areata (initial): 1) Patient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT), AND 2) Patient does not have primarily diffuse pattern alopecia (characterized by diffuse hair shedding) or other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss). For severe alopecia areata (continuation): Patient has achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	OMEGA-3
Drug Names	LOVAZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hypertriglyceridemia: Prior to the start of treatment with a triglyceride lowering drug, the patient has/had a pretreatment triglyceride level greater than or equal to 500 milligram per deciliter (mg/dL).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OMEPRAZOLE-BICARB CAPS
Drug Names	OMEPRAZOLE/SODIUM BICARBO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has experienced an inadequate treatment response to a one-month trial each of two proton pump inhibitors (PPIs), OR 2) The patient has experienced an intolerance or has a contraindication that would prohibit a one-month trial of two PPIs.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Maintenance of healing of erosive esophagitis: Plan Year, All other indications: 3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OMEPRAZOLE-BICARB POWDER
Drug Names	OMEPRAZOLE/SODIUM BICARBO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications except the reduction of risk of upper GI bleed in critically ill patients: 1) The patient has experienced an inadequate treatment response to a one-month trial each of two proton pump inhibitors (PPIs), OR 2) The patient has experienced an intolerance or has a contraindication that would prohibit a one-month trial of two PPIs, AND 3) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Maintenance of healing of erosive esophagitis: Plan Year, All other indications: 3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OMNIPOD
Drug Names	OMNIPOD 5 DEXCOM G7G6 INT, OMNIPOD 5 DEXCOM G7G6 POD, OMNIPOD 5 LIBRE INTRO KIT, OMNIPOD 5 LIBRE PODS, OMNIPOD DASH INTRO KIT (G, OMNIPOD DASH PODS (GEN 4)
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Initial: 1) The patient has diabetes requiring insulin management with multiple daily injections, AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor, AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OMVOH
Drug Names	OMVOH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Velsipity (etrasimod), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce). For moderately to severely active Crohn's disease (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ONAPGO
Drug Names	ONAPGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For advanced Parkinson's disease, continuation: The patient is experiencing improvement on the requested drug.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ONCASPAR
Drug Names	ONCASPAR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Extranodal natural killer/T-cell lymphoma, aggressive NK-cell leukemia (ANKL)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ONGENTYS
Drug Names	ONGENTYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ONTRUZANT
Drug Names	ONTRUZANT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	ONUREG
Drug Names	ONUREG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Peripheral T-cell lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OPDIVO
Drug Names	OPDIVO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OPDIVO QVANTIG
Drug Names	OPDIVO QVANTIG
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OPDUALAG
Drug Names	OPDUALAG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant systemic therapy for cutaneous melanoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OPFOLDA
Drug Names	OPFOLDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For late-onset Pompe disease: 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing AND 2) The requested drug will be used in combination with Pombiliti (cipaglucosidase alfa-atga) AND 3) Patient meets BOTH of the following: A) weighs at least 40 kilograms (kg), B) is not improving on their current enzyme replacement therapy (ERT).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	OPIPZA
Drug Names	OPIPZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of schizophrenia, 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Cobenfy, Lybalvi, Rexulti, Secuado, Vraylar, OR 2) The patient is unable to swallow oral formulations. For adjunctive treatment of major depressive disorder (MDD), 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Rexulti, Vraylar, OR 2) The patient is unable to swallow oral formulations. For treatment of irritability associated with autistic disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, risperidone, OR 2) The patient is unable to swallow oral formulations. For the treatment of Tourette's disorder: 1) The patient has had a trial of a generic formulation of aripiprazole or has an intolerance to generic aripiprazole, OR 2) The patient is unable to swallow oral formulations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OPSUMIT
Drug Names	MACITENTAN, OPSUMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OPSYNVI
Drug Names	OPSYNVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	OPZELURA
Drug Names	OPZELURA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis (AD) in a non-immunocompromised patient, initial therapy: 1) The requested drug will be applied to affected areas of 20 percent or less body surface area (BSA) AND 2) The patient meets either of the following: a) The requested drug will be used on sensitive areas (e.g., face, genitals, or skin folds) and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor, OR b) The requested drug will be used on non-sensitive (or remaining) skin areas and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor or a medium or higher potency topical corticosteroid. For the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient, continuation of therapy: The patient achieved or maintained positive clinical response. For the topical treatment of nonsegmental vitiligo (NSV): The requested drug will be applied to affected areas of 10 percent or less body surface area (BSA). For the topical treatment of nonsegmental vitiligo, continuation of therapy: The patient achieved or maintained meaningful repigmentation.
Age Restrictions	AD: 2 years of age or older, NSV: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	AD, Initial: 3 months, NSV, Initial: 7 months, AD, NSV Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	ORENCIA
Drug Names	ORENCIA, ORENCIA CLICKJECT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For an adult with active psoriatic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ORENITRAM
Drug Names	ORENITRAM, ORENITRAM TITRATION KIT M
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORGOVYX
Drug Names	ORGOVYX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORIAHNN
Drug Names	ORIAHNN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with any elagolix-containing drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months, max 24 months total
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORILISSA
Drug Names	ORILISSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe pain associated with endometriosis: the patient has not already received greater than or equal to 24 months of treatment with any elagolix-containing drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months, max 24 months total
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis (CF): the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORLADEYO
Drug Names	ORLADEYO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ORSERDU
Drug Names	ORSERDU
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer
Exclusion Criteria	-
Required Medical Information	Breast cancer: 1) the disease is estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2)-negative, and ESR1 mutated AND 2) the patient meets either of the following: a) the disease is advanced, recurrent, or metastatic AND the patient has disease progression following at least one line of endocrine therapy OR b) the disease had no response to preoperative systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OSPHENA
Drug Names	OSPHENA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OTEZLA
Drug Names	OTEZLA, OTEZLA XR, OTEZLA/OTEZLA XR 28 DAY T
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mild plaque psoriasis (new starts only): patient has experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial with topical corticosteroids. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce). For active psoriatic arthritis (PsA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OTREXUP
Drug Names	OTREXUP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Microscopic polyangiitis
Exclusion Criteria	-
Required Medical Information	Inability to prepare and administer generic injectable methotrexate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OXAZEPAM
Drug Names	OXAZEPAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), AND 2) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. For the management of anxiety disorders, anxiety associated with depression, and the management of anxiety, tension, agitation and irritability in older patients: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, Alcohol Withdrawal-Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	OXERVATE
Drug Names	OXERVATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	8 weeks
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OXICONAZOLE
Drug Names	OXICONAZOLE NITRATE, OXISTAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to the following: 1) clotrimazole cream AND 2) ketoconazole cream or shampoo.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OXLUMO
Drug Names	OXLUMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary hyperoxaluria type 1 (PH1): diagnosis has been confirmed by a molecular genetic test showing a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. For PH1 (continuation): the patient has experienced decreased or normalized levels of either of the following since initiating therapy: 1) urinary oxalate, 2) plasma oxalate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OXTELLAR XR
Drug Names	OXCARBAZEPINE ER, OXTELLAR XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri (if 18 years of age or older), Spritam.
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	OZEMPIC
Drug Names	OZEMPIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	OZEMPIC TAB
Drug Names	OZEMPIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PADCEV
Drug Names	PADCEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urothelial carcinoma, the requested drug will be used for treatment of any of the following: 1) locally advanced, recurrent, or metastatic urothelial carcinoma, OR 2) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder, OR 3) muscle invasive bladder cancer (MIBC).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PALSONIFY
Drug Names	PALSONIFY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PALYNZIQ
Drug Names	PALYNZIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PANRETIN
Drug Names	PANRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PAVBLU
Drug Names	PAVBLU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia.
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 12-48wks. HBV: 48wks. Other: Plan Yr
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	PEMAZYRE
Drug Names	PEMAZYRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PERJETA
Drug Names	PERJETA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), recurrent HER2-positive salivary gland tumors, brain metastases from HER2-positive breast cancer, unresectable or metastatic HER2-positive hepatobiliary cancers (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma).
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type AND 2) the requested drug is used in combination with trastuzumab AND 3) the patient has not had previous treatment with a HER2 inhibitor. For HER2-positive recurrent salivary gland tumors, brain metastases from HER2 positive breast cancer, and unresectable or metastatic HER2-positive hepatobiliary cancer (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma): the requested drug is used in combination with trastuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PHENYLBUTYRATE
Drug Names	BUPHENYL, OLPRUVA, PHEBURANE, SODIUM PHENYLBUTYRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic management of urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PHESGO
Drug Names	PHESGO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PIASKY
Drug Names	PIASKY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PIMECROLIMUS
Drug Names	PIMECROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Psoriasis on the face, genitals, or skin folds.
Exclusion Criteria	-
Required Medical Information	For mild to moderate atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is prescribed for short-term or non-continuous chronic use.
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	PIQRAY
Drug Names	PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, phosphatidylinositol-3-kinase catalytic alpha subunit (PIK3CA)-mutated breast cancer in combination with fulvestrant
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PLEGRIDY
Drug Names	PLEGRIDY, PLEGRIDY STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	POLIVY
Drug Names	POLIVY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorders (B-cell type), human immunodeficiency virus (HIV)-related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, human herpesvirus-8 [HHV8]-positive diffuse large B-cell lymphoma, not otherwise specified, and HIV-related plasmablastic lymphoma).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	POLYPHARMACY-ACH
Drug Names	AMOXAPINE, DICYCLOMINE HCL, DICYCLOMINE HYDROCHLORIDE, PAROXETINE, PAROXETINE HCL, PAROXETINE HCL ER, PAROXETINE HYDROCHLORIDE, PAXIL, PAXIL CR, PERPHENAZINE/AMITRIPTYLIN, PROMETHAZINE HYDROCHLORID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	No

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Prior Authorization Group	POMALYST
Drug Names	POMALIDOMIDE, POMALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: patient has previously received at least two prior therapies, including an immunomodulatory agent AND a proteasome inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	POMBILITI
Drug Names	POMBILITI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For late-onset Pompe disease: 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing AND 2) The requested drug will be used in combination with Opfolda (miglustat) AND 3) Patient meets BOTH of the following: A) weighs at least 40 kilograms (kg), B) is not improving on their current enzyme replacement therapy (ERT).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PONVORY
Drug Names	PONVORY, PONVORY 14-DAY STARTER PA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	POSACONAZOLE
Drug Names	POSACONAZOLE DR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs greater than 40 kilograms.
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	POTELIGEO
Drug Names	POTELIGEO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult T-cell leukemia/lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PRADAXA PAK
Drug Names	PRADAXA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	3 months to less than 12 years of age
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PREGABALIN
Drug Names	LYRICA, PREGABALIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer-related neuropathic pain, cancer treatment-related neuropathic pain
Exclusion Criteria	-
Required Medical Information	For all indications: If the request is for Lyrica (pregabalin) oral solution, the patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For the management of postherpetic neuralgia and management of neuropathic pain associated with diabetic peripheral neuropathy: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to generic gabapentin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	PREVYMIS
Drug Names	PREVYMIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant.
Age Restrictions	HSCT: 6 months of age or older, kidney transplant: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	7 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PRILOSEC POWDER
Drug Names	PRILOSEC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Treatment and prevention of nonsteroidal anti-inflammatory drug-induced gastrointestinal ulcer, esophageal strictures, dyspepsia, maintenance treatment of duodenal ulcers, Barrett's esophagus
Exclusion Criteria	-
Required Medical Information	Patient is unable to take oral solid dosage forms for any reason (e.g., difficulty swallowing tablets or capsules, requires administration via feeding tube).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	PROCRIT
Drug Names	PROCRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Anemia with CKD, zidovudine: Plan Year, All others: 16 weeks
Other Criteria	Coverage includes use in anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs). Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prerequisite Therapy Required	No

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Prior Authorization Group	PROCYSBI
Drug Names	PROCYSBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: 1) Diagnosis of was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has experienced an intolerance to prior therapy with Cystagon (cysteamine bitartrate immediate-release).
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	PROMACTA
Drug Names	ELTROMBOPAG OLAMINE, PROMACTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma), AND 3) For chronic ITP only: for an adult, pt has experienced an inadequate treatment response or intolerance to Doptelet (avatrombopag) or Alvaiz (eltrombopag), AND 4) For persistent ITP only: for an adult, pt has experienced an inadequate treatment response or intolerance to Alvaiz (eltrombopag). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): 1) the requested drug is used for initiation and maintenance of interferon-based therapy, AND 2) patient has experienced an inadequate treatment response or intolerance to Alvaiz (eltrombopag). For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): 1) Pt will use the requested drug with standard immunosuppressive therapy for first line treatment, OR 2) pt meets both of following: A) the pt had an insufficient response to immunosuppressive therapy and B) for an adult, pt has experienced an inadequate treatment response or intolerance to Alvaiz (eltrombopag).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
Other Criteria	For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).
Prerequisite Therapy Required	Yes

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Prior Authorization Group	PULMOZYME
Drug Names	PULMOZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	PYRUKYND
Drug Names	PYRUKYND, PYRUKYND TAPER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hemolytic anemia in a patient with pyruvate kinase (PK) deficiency: Diagnosis was confirmed by an enzyme assay demonstrating deficiency of PK enzyme activity or by genetic testing. For hemolytic anemia in a patient with PK deficiency (continuation of therapy): Patient achieved or maintained a positive clinical response (e.g., improvement in hemoglobin levels, reduction in blood transfusions).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 7 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	PYZCHIVA
Drug Names	PYZCHIVA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	QBREXZA
Drug Names	QBREXZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	QELBREE
Drug Names	QELBREE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient meets all of the following: 1) the patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD), AND 2) the patient will be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to atomoxetine OR the patient has difficulty swallowing oral capsules.
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	QINLOCK
Drug Names	QINLOCK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, recurrent, or progressive disease. Metastatic or unresectable cutaneous melanoma.
Exclusion Criteria	-
Required Medical Information	For residual, unresectable, tumor rupture, advanced, recurrent/metastatic, or progressive gastrointestinal stromal tumor (GIST): 1) Patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) Patient has experienced disease progression following treatment with avapritinib and dasatinib OR 3) Patient has received prior treatment with imatinib and is intolerant of second-line sunitinib. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	QUDEXY XR
Drug Names	TOPIRAMATE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For preventative treatment of migraine: The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product.
Age Restrictions	Epilepsy: 2 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	QUETIAPINE XR
Drug Names	QUETIAPINE FUMARATE ER, SEROQUEL XR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
Exclusion Criteria	-
Required Medical Information	For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls]. For treatment of schizophrenia: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of manic or mixed episodes associated with bipolar I disorder or maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of depressive episodes associated with bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: lurasidone, olanzapine, quetiapine immediate-release. For acute treatment of depressive episodes associated with bipolar II disorder: The patient experienced an inadequate treatment response or intolerance to generic quetiapine immediate-release. For adjunctive treatment of major depressive disorder (MDD): The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine immediate-release.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	QUININE SULFATE
Drug Names	QUININE SULFATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	-
Required Medical Information	For babesiosis: the requested drug is used in combination with clindamycin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	QULIPTA
Drug Names	QULIPTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	QUTENZA
Drug Names	QUTENZA, QUTENZA (2 PATCH), QUTENZA (4 PATCH)
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postherpetic neuralgia (PHN) and diabetic peripheral neuropathy (DPN) of the feet: The patient has experienced an inadequate treatment response to one month of generic gabapentin or has an intolerance or contraindication to gabapentin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	QUZYTTIR
Drug Names	QUZYTTIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	6 months of age or older
Prescriber Restrictions	-
Coverage Duration	6 weeks
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RADICAVA
Drug Names	EDARAVONE, RADICAVA ORS, RADICAVA ORS STARTER KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For amyotrophic lateral sclerosis (ALS): 1) Diagnosis is classified as definite or probable ALS, AND 2) For new starts only: Patient has scores of at least 2 points on all 12 areas of the revised ALS Functional Rating Scale (ALSFRS-R). For continuation of therapy for ALS: There is a clinical benefit from therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RAGWITEK
Drug Names	RAGWITEK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	-
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	RALDESY
Drug Names	RALDESY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient is unable to swallow trazodone tablets.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	RASUVO
Drug Names	RASUVO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Microscopic polyangiitis
Exclusion Criteria	-
Required Medical Information	Inability to prepare and administer generic injectable methotrexate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	RAVICTI
Drug Names	GLYCEROL PHENYLBUTYRATE, RAVICTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic management of urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REBIF
Drug Names	REBIF, REBIF REBIDOSE, REBIF REBIDOSE TITRATION, REBIF TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REBLOZYL
Drug Names	REBLOZYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For anemia with beta thalassemia or anemia in myelodysplastic syndromes or myelodysplastic/myeloproliferative neoplasm, patient meets the following: For new starts, the patient has a diagnosis of anemia evidenced by a pretreatment or pretransfusion hemoglobin level less than or equal to 11 grams per deciliter (g/dL). For continuation of therapy, patient meets all of the following: 1) patient has a pre-dose hemoglobin level less than or equal to 11 g/dL (the current or current pretransfusion hemoglobin level must be considered for dosing purposes) or the prescriber agrees to hold the dose until the hemoglobin level falls to or below 11 g/dL, 2) patient must achieve or maintain red blood cell transfusion burden reduction or they have not received three consecutive doses at the maximum dose, AND 3) patient must not experience an unacceptable toxicity on the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Beta thalassemia: 16 weeks, Myelodysplastic syndromes: 24 weeks
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REBYOTA
Drug Names	REBYOTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin or toxigenic C. difficile, AND 2) The requested drug will be administered 24 to 72 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RECORLEV
Drug Names	RECORLEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REDEMPLO
Drug Names	REDEMPLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For familial chylomicronemia syndrome (FCS) (e.g., lipoprotein lipase deficiency [LPLD] or Type 1 hyperlipoproteinemia), initial: 1) Diagnosis has been confirmed by any of the following: a) Genetic testing confirming biallelic mutations in FCS-causing genes (e.g., LPL, APOC2, APOA5, LMF1, GPIHBP1), b) North America familial chylomicronemia syndrome (NAFCS) score greater than or equal to 45, c) Moulin scoring greater than or equal to 10, AND 2) Patient has fasting triglycerides (TG) greater than or equal to 880 mg/dL. For FCS, continuation: Patient demonstrates positive clinical response to therapy (e.g., reduction in TG level from baseline, reduction in episodes of acute pancreatitis).
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, cardiologist, lipid specialist, geneticist, or prescriber specialized in treatment of FCS
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RELAFEN
Drug Names	RELAFEN DS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For relief of osteoarthritis and rheumatoid arthritis: The patient has tried generic nabumetone tablets.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	RELEUKO
Drug Names	RELEUKO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RELISTOR INJ
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation: 1) the patient is unable to tolerate oral medications, OR 2) the patient meets one of the following criteria: A) experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik), OR B) the patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	RELISTOR TAB
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RELTONE
Drug Names	RELTONE, URSODIOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For a patient with radiolucent, noncalcified gallbladder stones less than 20 millimeters in greatest diameter in whom elective cholecystectomy would be undertaken except for the presence of increased surgical risk due to systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery: the dosage cannot be accommodated with generic ursodiol 300 milligram (mg) capsules. For the prevention of gallstone formation in an obese patient experiencing rapid weight loss: the patient has experienced an intolerance to generic ursodiol 300 mg capsules due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	REMICADE
Drug Names	INFLIXIMAB, REMICADE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. For all indications: The patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	RENFLEXIS
Drug Names	RENFLEXIS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or has a contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or has a contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis.
Prerequisite Therapy Required	Yes

Prior Authorization Group	REPATHA
Drug Names	REPATHA, REPATHA SURECLICK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RETACRIT
Drug Names	RETACRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Anemia with CKD, zidovudine: Plan Year, All others: 16 weeks
Other Criteria	Coverage includes use in anemia in patients who will not/cannot receive blood transfusions (e.g., religious beliefs). Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prerequisite Therapy Required	No

Prior Authorization Group	RETEVMO
Drug Names	RETEVMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer (NSCLC), brain metastases from RET fusion-positive NSCLC, Langerhans cell histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, occult primary cancer with RET gene fusion, solid tumors with RET-gene fusion for recurrent disease
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC), patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement positive. For solid tumors, patient must meet all of the following: 1) The disease is recurrent, persistent, progressive, unresectable, locally advanced, or metastatic, 2) The patient has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options, AND 3) The tumor is RET fusion-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REVCOVI
Drug Names	REVCOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REVLIMID
Drug Names	LENALIDOMIDE, REVLIMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, Rosai-Dorfman disease, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), human immunodeficiency virus (HIV)-related B-cell lymphomas, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castlemans disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma
Exclusion Criteria	-
Required Medical Information	For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REVUFORJ
Drug Names	REVUFORJ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REYVOW
Drug Names	REYVOW
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute migraine: 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to Nurtec ODT (rimegepant) or Ubrelvy (ubrogepant).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	REZDIFFRA
Drug Names	REZDIFFRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For noncirrhotic nonalcoholic steatohepatitis (NASH), initial: patient has moderate to advanced liver fibrosis (consistent with Stages F2 to F3) at baseline, which was confirmed by liver biopsy or magnetic resonance elastography (MRE). For NASH (continuation): The patient demonstrates a beneficial response to therapy (for example, improvement in liver function such as reduction in alanine aminotransferase (ALT), reduction of liver fat content by imaging such as magnetic resonance imaging-protein density fat fraction (MRI-PDFF) or FibroScan controlled attenuation parameter (CAP)).
Age Restrictions	-
Prescriber Restrictions	The requested drug is being prescribed by, or in consultation with, a gastroenterologist or hepatologist.
Coverage Duration	Initial: Plan Year, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REZLIDHIA
Drug Names	REZLIDHIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	REZUROCK
Drug Names	REZUROCK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RHAPSIDO
Drug Names	RHAPSIDO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic spontaneous urticaria (CSU), initial: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Patient remains symptomatic despite H1 antihistamine treatment. For CSU continuation: Patient has experienced a benefit (e.g., improved symptoms since initiation of therapy).
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	CSU initial: 6 months, CSU continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	RIABNI
Drug Names	RIABNI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant hodgkin lymphoma, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, Pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and Pediatric mature B-cell acute leukemia (B-AL), neuromyelitis optica spectrum disorder
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	RINVOQ
Drug Names	RINVOQ, RINVOQ LQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis, active psoriatic arthritis, active polyarticular juvenile idiopathic arthritis, and active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab, etanercept). For moderately to severely active ulcerative colitis and moderately to severely active Crohn's disease: Patient meets one of the following: 1) Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab), OR 2) If a TNF inhibitor is clinically inadvisable, the patient has tried at least one systemic therapy. For atopic dermatitis (new starts only): 1) Patient has refractory, moderate to severe disease, AND 2) Patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): Patient achieved or maintained positive clinical response. For non-radiographic axial spondyloarthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.
Age Restrictions	Atopic dermatitis: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Atopic dermatitis (initial): 6 months, Atopic dermatitis (continuation), All others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant Hodgkin lymphoma, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, and pediatric aggressive mature B-cell lymphomas (including primary mediastinal large B-cell lymphoma), neuromyelitis optica spectrum disorder
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

Prior Authorization Group	RITUXAN HYCELA
Drug Names	RITUXAN HYCELA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Castleman disease (CD), high-grade B-cell lymphoma, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, marginal zone lymphomas (nodal marginal zone lymphoma, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous), and splenic marginal zone lymphoma), mantle cell lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, hairy cell leukemia, small lymphocytic lymphoma (SLL), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, nodular lymphocyte-predominant Hodgkin lymphoma
Exclusion Criteria	-
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RIVFLOZA
Drug Names	RIVFLOZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary hyperoxaluria type 1 (PH1): diagnosis has been confirmed by a molecular genetic test showing a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. For PH1 (continuation): the patient has experienced decreased or normalized levels of urinary oxalate since initiating therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ROLVEDON
Drug Names	ROLVEDON
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia, patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ROMVIMZA
Drug Names	ROMVIMZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ROZLYTREK
Drug Names	ROZLYTREK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, ROS1-gene fusion-positive cutaneous melanoma
Exclusion Criteria	-
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors: the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer: the patient has recurrent, advanced, or metastatic disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RUBRACA
Drug Names	RUBRACA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Uterine leiomyosarcoma, pancreatic adenocarcinoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer
Exclusion Criteria	-
Required Medical Information	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, AND 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, AND 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy, OR 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line or subsequent therapy, AND 2) the patient has BRCA-altered disease. For pancreatic adenocarcinoma: 1) the patient has metastatic disease, AND 2) the patient has somatic or germline BRCA or PALB-2 mutations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	RUCONEST
Drug Names	RUCONEST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an Immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RUXIENCE
Drug Names	RUXIENCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant Hodgkin, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and pediatric mature B-cell acute leukemia (B-AL), neuromyelitis optica spectrum disorder
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Prerequisite Therapy Required	Yes

Prior Authorization Group	RYBELSUS
Drug Names	RYBELSUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RYBREVANT
Drug Names	RYBREVANT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) mutation-positive disease
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer: 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RYBREVANT FASPRO
Drug Names	RYBREVANT FASPRO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) mutation-positive disease
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer: 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RYDAPT
Drug Names	RYDAPT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Re-induction in residual disease for AML, maintenance therapy for AML, myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	RYLAZE
Drug Names	RYLAZE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Nasal type extranodal natural killer (NK)/T-cell lymphoma (ENKTL), Aggressive NK-cell leukemia (ANKL)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RYSTIGGO
Drug Names	RYSTIGGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For generalized myasthenia gravis (gMG), continuation: 1) There is no evidence of unacceptable toxicity while on the current regimen AND 2) Patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	RYTELO
Drug Names	RYTELO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For new starts, patient meets all of the following: 1) patient has not responded to, has lost response to, or is ineligible for erythropoiesis-stimulating agents (ESAs), AND 2) patient has been receiving regular red blood cell transfusions as defined by greater than or equal to 4 units per 8 weeks. For continuation of therapy, patient meets all of the following: 1) patient must achieve or maintain red blood cell transfusion burden reduction, AND 2) patient must not experience an unacceptable toxicity on the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 weeks
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	RYZNEUTA
Drug Names	RYZNEUTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia, patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SAMSCA
Drug Names	SAMSCA, TOLVAPTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hypervolemic and euvolemic hyponatremia: 1) Therapy with the requested drug was initiated (or re-initiated) in the hospital AND 2) The patient meets one of the following: a) serum sodium less than 125 milliequivalents per liter (mEq/L) or b) serum sodium was less than 135 mEq/L with symptoms (e.g., nausea, vomiting, headache, lethargy, confusion), AND 3) the patient will not receive the requested medication for greater than 30 days continuously.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	30 days
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SANDOSTATIN LAR
Drug Names	OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tumor control of the following indications: thymomas and thymic carcinomas, neuroendocrine tumors (NETs) (including tumors of the pancreas, gastrointestinal tract, lung, thymus, unresected primary gastrinoma, well-differentiated grade 3 NETs with favorable biology, pheochromocytoma, and paraganglioma), and meningiomas
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SANTYL
Drug Names	SANTYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For debriding chronic dermal ulcers and severely burned areas, continuation: 1) wound has been evaluated since beginning treatment with the requested drug AND 2) granulation tissue is not well established.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	SAPHNELO
Drug Names	SAPHNELO, SAPHNELO PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	For patients new to therapy: severe active lupus nephritis and severe active central nervous system lupus.
Required Medical Information	For moderate to severe systemic lupus erythematosus (SLE): 1) patient is currently receiving a standard therapy regimen for SLE (for example, corticosteroid, antimalarial, or NSAIDs) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE, AND 3) for initial starts, patient has confirmed diagnosis of SLE from positive autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins).
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SAPROPTERIN
Drug Names	JAVYGTOR, KUVAN, SAPROPTERIN DIHYDROCHLORI, ZELVYSIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months, All others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SARCLISA
Drug Names	SARCLISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SARCLISA ESCENA
Drug Names	SARCLISA ESCENA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SAVELLA
Drug Names	MILNACIPRAN HYDROCHLORIDE, SAVELLA, SAVELLA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For fibromyalgia: 1) patient has experienced an inadequate treatment response or intolerance to duloxetine or pregabalin, OR 2) patient has a contraindication to both duloxetine and pregabalin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	SCEMBLIX
Drug Names	SCEMBLIX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) in chronic phase: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) Patient meets one of the following: A) Patient has newly diagnosed CML and has resistance or intolerance to imatinib, dasatinib, or nilotinib OR B) Patient has previously treated CML AND at least one of the prior treatments was imatinib, dasatinib, or nilotinib OR C) Patient is positive for the T315I mutation, AND 3) Patient is negative for the following mutations: A337T, P465S, and F359V/I/C.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SEPHIENCE
Drug Names	SEPHIENCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SEROSTIM
Drug Names	SEROSTIM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of human immunodeficiency virus (HIV) patients with wasting or cachexia: 1) The requested medication is used in combination with antiretroviral therapy AND 2) Patient meets any of the following: a) has had a suboptimal response to at least one other therapy for wasting or cachexia (e.g., megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal), b) patient has a contraindication or intolerance to alternative therapies. For continuation of therapy: Patient must have demonstrated a response to therapy with the requested medication (i.e., body mass index [BMI] has increased or stabilized).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SEYSARA
Drug Names	SEYSARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For inflammatory lesions of non-nodular moderate to severe acne vulgaris: 1) The patient has experienced an inadequate treatment response to doxycycline (regular or extended-release) or minocycline (regular or extended-release) OR 2) The patient has experienced an intolerance to doxycycline (regular or extended-release) or minocycline (regular or extended-release).
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SIGNIFOR LAR
Drug Names	SIGNIFOR LAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial therapy: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery OR there is a clinical reason for why the patient has not had surgery. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SILDENAFIL
Drug Names	REVATIO, SILDENAFIL CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SILDENAFIL INJ
Drug Names	REVATIO, SILDENAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	Patient was previously receiving oral Revatio or sildenafil but is now temporarily unable to take oral medications.
Prerequisite Therapy Required	No

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Prior Authorization Group	SILIQ
Drug Names	SILIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	SIMPONI
Drug Names	SIMPONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Requested drug will be used in combination with methotrexate (MTX) unless MTX is contraindicated or was not tolerated AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active ulcerative colitis (new starts only): Adult patients have experienced an inadequate treatment response, intolerance, or have a contraindication to two of the following products: adalimumab-bwwd, Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Velsipity (etrasimod), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For active psoriatic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Prerequisite Therapy Required	Yes

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Prior Authorization Group	SIMPONI ARIA
Drug Names	SIMPONI ARIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Requested drug will be used in combination with methotrexate (MTX) unless MTX is contraindicated or was not tolerated AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For an adult with active psoriatic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce). For active polyarticular juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SKYCLARYS
Drug Names	SKYCLARYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Friedreich's ataxia (FRDA): 1) The patient has a confirmed genetic mutation in the frataxin (FXN) gene, AND 2) The patient exhibits clinical manifestations of the disease (for example, muscle weakness, decline in coordination, frequent falling). For FRDA continuation of therapy: The patient has experienced a beneficial response to therapy (for example, slowing of clinical decline).
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in Friedreich's ataxia or a neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SKYRIZI
Drug Names	SKYRIZI, SKYRIZI PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SKYTROFA
Drug Names	SKYTROFA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For pediatric growth hormone deficiency (GHD), initial: A) Patient (pt) meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean, OR B) pt was diagnosed with GHD as a neonate.
Age Restrictions	Pediatric GHD: 1 year of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	For adult GHD: Patient meets ANY of the following: 1) failed 2 pre-treatment growth hormone (GH) stimulation tests, OR 2) pre-treatment insulin-like growth factor-1 (IGF-1) more than 2 standard deviations (SD) below mean AND failed 1 pre-treatment GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-treatment IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. For pediatric and adult GHD, continuation of therapy: Patient is experiencing improvement.
Prerequisite Therapy Required	No

Prior Authorization Group	SOFDRA
Drug Names	SOFDRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	9 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SOGROYA
Drug Names	SOGROYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patient with closed epiphyses
Required Medical Information	For adult GHD: Patient meets ANY of the following: 1) failed 2 pre-treatment growth hormone (GH) stimulation tests, OR 2) pre-treatment insulin-like growth factor-1 (IGF-1) more than 2 standard deviations (SD) below mean AND failed 1 pre-treatment GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-treatment IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS.
Age Restrictions	Pediatric GHD, SGA, NS, ISS: 2.5 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	For pediatric growth hormone deficiency (GHD): 1) Patient (pt) has pre-treatment (pre-tx) 1-year height (ht) velocity more than 2 standard deviations (SD) below mean OR a pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND pt meets any of the following: a) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), b) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean, OR 2) Pt was diagnosed with GHD as a neonate. For small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. For pediatric GHD, SGA, and adult GHD, continuation of therapy: Patient is experiencing improvement.
Prerequisite Therapy Required	No

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Prior Authorization Group	SOLIRIS
Drug Names	SOLIRIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The patient (pt) has demonstrated a positive response to therapy. For atypical hemolytic uremic syndrome (aHUS) (initial): The disease is not caused by Shiga toxin-producing Escherichia coli. For aHUS (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy. For generalized myasthenia gravis (continuation): 1) There is no evidence of unacceptable toxicity while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy. For neuromyelitis optica spectrum disorder (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	LANREOTIDE ACETATE, SOMATULINE DEPOT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tumor control of neuroendocrine tumors (NETs) (including tumors of the lung, thymus, unresected primary gastrinoma, well-differentiated grade 3 NETs not of gastroenteropancreatic origin with favorable biology, and pheochromocytoma/paraganglioma)
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SOOLANTRA
Drug Names	IVERMECTIN, SOOLANTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SOTYKTU
Drug Names	SOTYKTU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SPEVIGO
Drug Names	SPEVIGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SPRAVATO
Drug Names	SPRAVATO 56MG DOSE, SPRAVATO 84MG DOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment-resistant depression (TRD) initial therapy: 1) Confirmed diagnosis of severe major depressive disorder (single or recurrent episode) by standardized rating scales that reliably measure depressive symptoms (e.g., Beck's Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.), AND 2) Inadequate response with a therapeutic dose of, or intolerance to, at least two antidepressant agents during the current depressive episode. For TRD continuation of therapy: Improvement or sustained improvement from baseline in depressive symptoms as evidenced by standardized rating scales that reliably measure depressive symptoms. For Major Depressive Disorder (MDD) with acute suicidal ideation or behavior: 1) Confirmed diagnosis of severe major depressive disorder (single or recurrent episode) by standardized rating scales that reliably measure depressive symptoms (e.g., Beck's Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.), AND 2) Patient will use the requested drug in combination with an oral antidepressant.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	TRD Initial: 3 months, TRD Continuation: Plan Year, MDD: 1 month
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	SPRYCEL
Drug Names	DASATINIB, PHYRAGO, SPRYCEL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gastrointestinal stromal tumor (GIST), metastatic and/or widespread chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, cutaneous melanoma
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: Diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene AND if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L OR 2) Ph-like B-ALL with ABL-class kinase fusion OR 3) Relapsed or refractory T-cell ALL with ABL-class translocation. For gastrointestinal stromal tumor (GIST): 1) Patient meets all of the following: A) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, B) Patient has received prior therapy with avapritinib AND C) Patient is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutations. For cutaneous melanoma: 1) Disease is metastatic or unresectable, 2) Disease is positive for c-KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	STELARA
Drug Names	STELARA, USTEKINUMAB
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	STIMUFEND
Drug Names	STIMUFEND
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Osteosarcoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, soft tissue sarcomas of the extremities, body wall, head and neck, appendiceal adenocarcinoma
Exclusion Criteria	-
Required Medical Information	For colorectal cancer: 1) The disease is advanced or metastatic, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Lonsurf (trifluridine/tipiracil).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	STRENSIQ
Drug Names	STRENSIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of perinatal/infantile- and juvenile-onset hypophosphatasia: 1) The patient has clinical signs and/or symptoms of hypophosphatasia (e.g., generalized hypomineralization with rachitic features, chest deformities and rib fractures, respiratory problems, hypercalcemia, failure to thrive, bone/joint pain, seizures) AND 2) The onset of the disease was perinatal/infantile or juvenile AND 3) The diagnosis was confirmed by the presence of mutation(s) in the ALPL gene as detected by ALPL molecular genetic testing OR the diagnosis was supported by ALL of the following: a) radiographic imaging demonstrating skeletal abnormalities (e.g., infantile rickets, alveolar bone loss, focal bony defects of the metaphyses, metatarsal stress fractures), b) low serum alkaline phosphatase (ALP) level as defined by the gender- and age-specific reference range of the laboratory performing the test, c) elevated tissue-nonspecific alkaline phosphatase (TNALP) substrate level (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi] level).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SUCRAID
Drug Names	SUCRAID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For congenital sucrase-isomaltase deficiency: 1) The diagnosis was confirmed by small bowel biopsy, OR 2) The diagnosis was confirmed by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SUNOSI
Drug Names	SUNOSI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For excessive daytime sleepiness associated with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For excessive daytime sleepiness associated with obstructive sleep apnea (OSA), initial request: 1) The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in daytime sleepiness with obstructive sleep apnea (OSA).
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	SUSVIMO
Drug Names	SUSVIMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	SUTENT
Drug Names	SUNITINIB MALATE, SUTENT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, medullary, papillary, and oncocytic), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, alveolar soft part sarcoma, and extraskeletal myxoid chondrosarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase, pheochromocytoma, paraganglioma, well differentiated grade 3 neuroendocrine tumors
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma (RCC): 1) The disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SYFOVRE
Drug Names	SYFOVRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	SYLVANT
Drug Names	SYLVANT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory unicentric Castleman's disease in patients who are human immunodeficiency virus negative and human herpesvirus-8 negative
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SYMLIN
Drug Names	SYMLINPEN 120, SYMLINPEN 60
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SYMPAZAN
Drug Names	SYMPAZAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	SYNAREL
Drug Names	SYNAREL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years of age if female and less than 13 years of age if male, Endometriosis: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	CPP: Plan Year, Endometriosis: max 6 months total
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TABLOID
Drug Names	TABLOID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute lymphocytic leukemia (ALL), circumscribed glioma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TABRECTA
Drug Names	TABRECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) brain metastases from MET exon-14 mutated NSCLC
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TADALAFIL (BPH)
Drug Names	CIALIS, TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Erectile Dysfunction.
Required Medical Information	For benign prostatic hyperplasia (BPH): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to both of the following: 1) alpha blocker, 2) 5-alpha reductase inhibitor (5-ARI).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TADALAFIL (PAH)
Drug Names	ADCIRCA, ALYQ, TADALAFIL, TADLIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, hairy cell leukemia.
Exclusion Criteria	-
Required Medical Information	For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The tumor is BRAF V600E-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) the requested drug will be used in combination with trametinib. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For hairy cell leukemia: 1) the requested drug will be used in combination with trametinib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has unresectable, metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease, OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TAKHZYRO
Drug Names	TAKHZYRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an Immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	TALTZ
Drug Names	TALTZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce). For active ankylosing spondylitis (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (PsA) (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce). For active non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-bwwd, Bimzelx (bimekizumab-bkzx), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TALZENNA
Drug Names	TALZENNA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TARGRETIN TOPICAL
Drug Names	BEXAROTENE, TARGRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS), smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TARPEYO
Drug Names	TARPEYO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For patients with primary immunoglobulin A nephropathy (IgAN) at risk of disease progression: patient is on a stable dose of a maximally-tolerated renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) or patient has experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	10 months
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	TASCENSO
Drug Names	TASCENSO ODT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TASIGNA
Drug Names	NILOTINIB HYDROCHLORIDE, TASIGNA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor, cutaneous melanoma
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. For gastrointestinal stromal tumor (GIST): 1) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, AND 2) Disease has progressed on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g. imatinib, sunitinib, regorafenib, ripretinib). For cutaneous melanoma: 1) Disease is metastatic or unresectable, AND 2) Disease is positive for c-KIT activating mutations, AND 3) Requested drug will be used as subsequent therapy, AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TAVALISSE
Drug Names	TAVALISSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic immune thrombocytopenia (ITP) (new starts): patient meets ALL of the following: 1) Patient has experienced an inadequate treatment response or is intolerant to a prior therapy (e.g., corticosteroid, immunoglobulin, thrombopoietin receptor agonist), AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation): platelet count response to the requested drug must meet ONE of the following: 1) current platelet count is less than or equal to 200,000/mcL, OR 2) current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 12 weeks, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TAVNEOS
Drug Names	TAVNEOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TAZAROTENE
Drug Names	TAZARAC, TAZORAC, TRILITAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TECENTRIQ
Drug Names	TECENTRIQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, urothelial carcinoma, stage IIIB non-small cell lung cancer (NSCLC), cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix).
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TECENTRIQ HYBREZA
Drug Names	TECENTRIQ HYBREZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix), stage IIIB non-small cell lung cancer (NSCLC), subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, bladder cancer, urothelial carcinoma.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TECFIDERA
Drug Names	DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER, TECFIDERA, TECFIDERA STARTER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	TECVAYLI
Drug Names	TECVAYLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TEMAZEPAM
Drug Names	RESTORIL, TEMAZEPAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg) or ramelteon, AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]..
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.
Prerequisite Therapy Required	Yes

Prior Authorization Group	TEPEZZA
Drug Names	TEPEZZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Thyroid Eye Disease: The patient has not previously received 8 or more infusions of the requested drug.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist
Coverage Duration	6 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TEPMETKO
Drug Names	TEPMETKO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) cancer including brain metastases and leptomeningeal metastases from MET exon-14 mutated NSCLC
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TERBINAFINE TABS
Drug Names	TERBINAFINE HCL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of onychomycosis due to dermatophytes (tinea unguium), patient meets ALL of the following: 1) the patient will use the requested drug orally., AND 2) the requested drug is being prescribed for non-continuous use.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	Prior authorization applies to greater than cumulative 90 days of therapy per year.
Prerequisite Therapy Required	No

Prior Authorization Group	TERIPARATIDE
Drug Names	BONSITY, TERIPARATIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For glucocorticoid-induced osteoporosis: patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 24 months, Continuation: Plan Year
Other Criteria	Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Patient has high FRAX fracture probability if the 10-year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.
Prerequisite Therapy Required	Yes

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Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	AZMIRO, DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	TESTOSTERONE ENANTHATE INJ
Drug Names	TESTOSTERONE ENANTHATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE, XENAZINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tic disorders, tardive dyskinesia
Exclusion Criteria	-
Required Medical Information	For treatment of chorea associated with Huntington's disease, initial: patient must meet both of the following:1) patient demonstrates characteristic motor examination features, AND 2) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For tardive dyskinesia, initial: patient must meet all of the following: 1) patient exhibits clinical manifestation of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]), AND 3) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TETRACYCLINE TAB
Drug Names	TETRACYCLINE HYDROCHLORID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an intolerable adverse event to tetracycline capsules caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TEVIMBRA
Drug Names	TEVIMBRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hepatocellular carcinoma
Exclusion Criteria	-
Required Medical Information	For hepatocellular carcinoma: 1) the disease is unresectable, metastatic, or extrahepatic, AND 2) the requested drug will be used as a single agent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TEZSPIRE
Drug Names	TEZSPIRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma, initial therapy: patient has a history of severe asthma despite current treatment with both of the following medications: 1) medium-to-high-dose inhaled corticosteroid, 2) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) If the patient is 18 years of age or older, patient has experienced an inadequate treatment response to Xhance (fluticasone).
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	THALOMID
Drug Names	THALOMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis, Kaposi sarcoma, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis, pediatric medulloblastoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TIBSOVO
Drug Names	TIBSOVO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Conventional (grades 1-3) or dedifferentiated chondrosarcoma, central nervous system (CNS) cancers (astrocytoma, oligodendroglioma)
Exclusion Criteria	-
Required Medical Information	Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient declines or has comorbidities that preclude use of intensive induction chemotherapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) therapy will be used for consolidation therapy. For locally advanced, unresectable, resected gross residual, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment. For CNS cancers: 1) disease is recurrent, residual, or progressive, AND 2) patient has oligodendroglioma or astrocytoma.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TIGLUTIK
Drug Names	TIGLUTIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For amyotrophic lateral sclerosis (ALS): 1) Patient requires administration of the requested drug via a percutaneous endoscopic gastrostomy tube (PEG-tube) OR 2) Patient has difficulty swallowing solid oral dosage forms (e.g., tablets).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TIVDAK
Drug Names	TIVDAK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Metastatic or recurrent vaginal cancer
Exclusion Criteria	-
Required Medical Information	For vaginal cancer: 1) Disease is recurrent or metastatic, AND 2) The requested drug is being used for subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TLANDO
Drug Names	TLANDO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TOBI INHALER
Drug Names	TOBI PODHALER
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TOBRAMYCIN
Drug Names	BETHKIS, KITABIS PAK, TOBI, TOBRAMYCIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TOBRAMYCIN INJ
Drug Names	TOBRAMYCIN SULFATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient will be using the requested drug intramuscularly or intravenously.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TOFIDENCE
Drug Names	TOFIDENCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Castleman's disease, systemic sclerosis-associated interstitial lung disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For giant cell arteritis (GCA) (new starts only): patient has experienced an intolerable adverse event to one of the following products: Rinvoq (upadacitinib) or Tyenne (tocilizumab-aazg) and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For systemic juvenile idiopathic arthritis (sJIA) (new starts only): patient has experienced an intolerable adverse event to Tyenne (tocilizumab-aazg) and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TOLSURA
Drug Names	TOLSURA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TONMYA
Drug Names	TONMYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For fibromyalgia: 1) patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to duloxetine or pregabalin, OR b) patient has a contraindication to both duloxetine and pregabalin, AND 2) if the patient is 65 years of age or older, the patient meets both of the following: a) prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), AND b) if the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TOPICAL DOXEPIN
Drug Names	DOXEPIN HYDROCHLORIDE, PRUDOXIN, ZONALON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TOPICAL LIDOCAINE
Drug Names	GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE HYDROCHLORIDE, LIDOCAINE HYDROCHLORIDE J
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TOPICAL TACROLIMUS
Drug Names	TACROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Psoriasis on the face, genitals, or skin folds.
Exclusion Criteria	-
Required Medical Information	For moderate to severe atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is being prescribed for short-term or non-continuous chronic use.
Age Restrictions	Tacrolimus 0.03% 2 years of age or older, Tacrolimus 0.1% 16 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	TESTIM, TESTOSTERONE, TESTOSTERONE PUMP, VOGELXO, VOGELXO PUMP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TOPICAL TRETINOIN
Drug Names	ALTRENO, ATRALIN, CLINDAMYCIN PHOSPHATE/TRE, RETIN-A, RETIN-A MICRO, RETIN-A MICRO PUMP, TRETINOIN, TRETINOIN MICROSPHERE, TRETINOIN MICROSPHERE PUM, TWYNEO, ZIANA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TOREMIFENE
Drug Names	FARESTON, TOREMIFENE CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia.
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TRAZIMERA
Drug Names	TRAZIMERA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer.
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib AND 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

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Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender dysphoria, breast cancer, salivary gland tumors, uterine sarcoma
Exclusion Criteria	-
Required Medical Information	For gender dysphoria (GD): 1) The patient is able to make an informed decision to engage in treatment, and 2) The patient meets ONE of the following: a) The requested drug will be used for pubertal hormonal suppression and the patient has reached Tanner stage 2 of puberty or greater, or b) The patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones. For breast cancer, patient meets ALL of the following: 1) The requested drug is being used for ovarian suppression in premenopausal patients, and 2) The requested drug will be used in combination with endocrine therapy, and 3) The disease is hormone receptor positive, and 4) The disease is at a higher risk of recurrence (for example, young age, high-grade tumor, lymph-node involvement). For salivary gland tumors: 1) The disease is androgen receptor positive, and 2) The disease is recurrent, metastatic, or unresectable. For uterine sarcoma: The requested drug is being used in combination with an aromatase inhibitor in premenopausal patients who are not suitable for surgery.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TREMFYA
Drug Names	TREMFYA, TREMFYA INDUCTION PACK FO, TREMFYA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TREPROSTINIL INJ
Drug Names	REMODULIN, TREPROSTINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TRIENTINE
Drug Names	SYPRINE, TRIENTINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TRIESENCE
Drug Names	TRIESENCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TRIKAFTA
Drug Names	TRIKAFTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TRINTELLIX
Drug Names	TRINTELLIX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ONE of the following generic products: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TRODELVY
Drug Names	TRODELVY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent or metastatic urothelial carcinoma
Exclusion Criteria	-
Required Medical Information	For urothelial carcinoma, the requested drug will be used as subsequent therapy for any of the following: 1) recurrent, or metastatic urothelial carcinoma, OR 2) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder. For breast cancer: 1) the disease is recurrent, advanced, or metastatic, or unresponsive to preoperative systemic therapy, AND 2) the patient has triple-negative, or hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TROKENDI XR
Drug Names	TOPIRAMATE ER, TROKENDI XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri (if 18 years of age or older), Spritam. For monotherapy treatment of primary generalized tonic-clonic seizures: The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For preventative treatment of migraine: The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product.
Age Restrictions	Epilepsy: 6 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TRUDHESA
Drug Names	TRUDHESA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 receptor agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	TRULICITY
Drug Names	TRULICITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	For glycemic control in type 2 diabetes mellitus: 10 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TRUQAP
Drug Names	TRUQAP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer.
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) the disease is recurrent, locally advanced, or metastatic, 2) the disease is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative, 3) the requested drug will be used in combination with fulvestrant, 4) the disease possesses one or more PIK3CA/AKT/PTEN-alterations AND the patient meets either of the following, a) the patient has progressed on at least one endocrine therapy based regimen, b) the patient experienced recurrence on or within 12 months of completing adjuvant therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	TRUTAKNA
Drug Names	TRUTAKNA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For reduction of proteinuria in patients with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]), OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TRUXIMA
Drug Names	TRUXIMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant Hodgkin lymphoma, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and pediatric mature B-cell acute leukemia, neuromyelitis optica spectrum disorder
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TRYNGOLZA
Drug Names	TRYNGOLZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For familial chylomicronemia syndrome (FCS) (e.g., lipoprotein lipase deficiency (LPLD) or Type 1 hyperlipoproteinemia), initial: 1) Diagnosis has been confirmed by any of the following: a) Genetic testing confirming biallelic mutations in FCS-causing genes (e.g., LPL, APOC2, APOA5, LMF1, GPIHBP1), b) North America familial chylomicronemia syndrome (NAFCS) score greater than or equal to 45, c) Moulin scoring greater than or equal to 10, AND 2) Patient has fasting triglycerides (TG) greater than or equal to 880 mg/dL. For FCS, continuation: Patient demonstrates positive clinical response to therapy (e.g., reduction in TG level from baseline, reduction in episodes of acute pancreatitis).
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, cardiologist, lipid specialist, geneticist, or prescriber specialized in treatment of FCS
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TRYPTYR
Drug Names	TRYPTYR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For signs and symptoms of dry eye disease (DED): 1) Patient has experienced an inadequate treatment response or intolerance to Restasis (cyclosporine 0.05 percent emulsion) AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	TRYVIO
Drug Names	TRYVIO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hypertension: 1) the patient is currently taking other antihypertensive drugs (e.g., angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], beta-blocker, calcium channel blocker, diuretics) at maximally tolerated doses AND 2) for initial therapy, the patient's blood pressure is not adequately controlled with their current regimen. For continuation: the patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TUKYSA
Drug Names	TUKYSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, HER2-positive biliary tract cancer (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the patient has RAS wild-type disease, AND 4) the requested drug will be used in combination with trastuzumab, AND 5) the patient has not previously been treated with a HER2 inhibitor. For biliary tract cancer: 1) the patient has unresectable or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the requested drug will be used in combination with trastuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TURALIO
Drug Names	TURALIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease
Exclusion Criteria	-
Required Medical Information	For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation, AND 2) patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TYENNE
Drug Names	TYENNE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Castleman's disease, systemic sclerosis-associated interstitial lung disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance or contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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

Prior Authorization Group	TYRUKO
Drug Names	TYRUKO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one conventional therapy option (e.g., corticosteroids) AND one tumor necrosis factor (TNF) inhibitor indicated for Crohn's disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TYRVAYA
Drug Names	TYRVAYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For signs and symptoms of dry eye disease: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: Restasis (cyclosporine 0.05 percent emulsion), Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TYSABRI
Drug Names	TYSABRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one conventional therapy option (e.g., corticosteroids) AND one tumor necrosis factor (TNF) inhibitor indicated for Crohn's disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	TYVASO
Drug Names	TYVASO, TYVASO REFILL KIT, TYVASO STARTER KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1) or pulmonary hypertension associated with interstitial lung disease (WHO Group 3) : the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	TYVASO DPI
Drug Names	TYVASO DPI INSTITUTIONAL, TYVASO DPI MAINTENANCE KI, TYVASO DPI TITRATION KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1) or pulmonary hypertension associated with interstitial lung disease (WHO Group 3) : the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	TZIELD
Drug Names	TZIELD
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the delay of Stage 3 type 1 diabetes (T1D): 1) The patient has a diagnosis of Stage 2 T1D that was confirmed by both of the following: a) at least two positive pancreatic islet cell autoantibodies AND b) dysglycemia without overt hyperglycemia using an oral glucose tolerance test (OGTT) or alternative method if appropriate, AND 2) The clinical history of the patient does not suggest type 2 diabetes. For the delay in the decline in endogenous insulin production in Stage 3 type 1 diabetes (T1D): 1) The patient has a diagnosis of Stage 3 T1D that was confirmed by both of the following: a) at least one positive pancreatic islet cell autoantibody, AND b) peak C-peptide greater than or equal to 0.2 picomoles per milliliter on a mixed-meal tolerance test or alternative method if appropriate, AND 2) if initial treatment, the requested drug will be administered within 8 weeks from date of confirmed diagnosis.
Age Restrictions	Delay of stage 3 T1D: 1 year of age or older, delay the decline in endogenous insulin production: 8 to 17 years of age
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Delay of stage 3 T1D: 1 month, Delay the decline in endogenous insulin production: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	UBRELVY
Drug Names	UBRELVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	UCERIS
Drug Names	BUDESONIDE ER, UCERIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the induction of remission of active, mild to moderate ulcerative colitis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	2 months
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	UDENYCA
Drug Names	UDENYCA, UDENYCA ONBODY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ULTOMIRIS
Drug Names	ULTOMIRIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs), AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) Patient has demonstrated a positive response to therapy. For atypical hemolytic uremic syndrome (aHUS) (initial): The disease is not caused by Shiga toxin-producing Escherichia coli. For aHUS (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) Patient has demonstrated a positive response to therapy. For generalized myasthenia gravis (gMG) (continuation): 1) There is no evidence of unacceptable toxicity while on the current regimen, AND 2) Patient has demonstrated a positive response to therapy. For neuromyelitis optica spectrum disorder (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) The pt has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	UNLOXCYT
Drug Names	UNLOXCYT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	UPLIZNA
Drug Names	UPLIZNA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For neuromyelitis optica spectrum disorder (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen, AND 2) the patient has demonstrated a positive response to therapy. For Immunoglobulin G4-related disease (IgG4-RD) (initial): the diagnosis is confirmed based on clinical, serologic, radiologic, and pathologic evaluations. For IgG4-RD (continuation): the patient has demonstrated a positive response to therapy (e.g., reduction in flares, complete remission). For generalized myasthenia gravis (continuation): 1) there is no evidence of unacceptable toxicity while on the current regimen, AND 2) the patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	NMOSD Initial: 6 months, NMOSD continuation, All others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI, UPTRAVI TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) if the request is for an adult, pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	URSOLIGN
Drug Names	URSOLIGN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For a patient with radiolucent, noncalcified gallbladder stones less than 20 millimeters in greatest diameter in whom elective cholecystectomy would be undertaken except for the presence of increased surgical risk due to systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery: the dosage cannot be accommodated with generic ursodiol 300 milligram (mg) capsules. For the prevention of gallstone formation in an obese patient experiencing rapid weight loss: the patient has experienced an intolerance to generic ursodiol 300 mg capsules due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	V-GO
Drug Names	V-GO 20, V-GO 30, V-GO 40
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Initial: 1) The patient has diabetes requiring insulin management with multiple daily injections, AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor, AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VABRINTY
Drug Names	VABRINTY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Salivary gland tumors
Exclusion Criteria	-
Required Medical Information	For salivary gland tumors: 1) the disease is androgen receptor positive AND 2) the disease is recurrent, metastatic, or unresectable.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VABYSMO
Drug Names	VABYSMO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VANFLYTA
Drug Names	VANFLYTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Re-induction in patients with residual disease for AML
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): 1) AML is FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive and 2) medication will be used for induction, re-induction, consolidation, or maintenance therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VANRAFIA
Drug Names	VANRAFIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For reduction of proteinuria in patients with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VEGZELMA
Drug Names	VEGZELMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	VELCADE
Drug Names	BORTEZOMIB, BORUZU, VELCADE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, Kaposi's sarcoma, pediatric Classic Hodgkin lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

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Prior Authorization Group	VELSIPITY
Drug Names	VELSIPITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VEMLIDY
Drug Names	VEMLIDY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis B virus infection (new starts only): 1) patient has compensated liver disease, AND 2) patient meets either of the following: a) has experienced an inadequate virologic response or intolerable adverse event to tenofovir disoproxil fumarate, OR b) has bone loss and mineralization defects or is at risk for bone loss and mineralization defects (for example, history of fragility fractures, advanced age, frailty, chronic glucocorticoid use, low T-scores, or increased fall risk).
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), poor-risk AML, therapy related AML, post-induction therapy for AML following response to previous lower intensity therapy with the same regimen, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), accelerated or blast phase myeloproliferative neoplasms, B-cell acute lymphoblastic leukemia/T-cell acute lymphoblastic leukemia (B-ALL/T-ALL), hairy cell leukemia, higher risk myelodysplastic syndromes, chronic myelomonocytic leukemia (CMML)-2.
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 2) will be used for induction or consolidation therapy in patients with poor-risk or therapy related AML, OR 3) patient has relapsed or refractory AML, OR 4) will be used for post-induction therapy for AML following response to previous lower intensity therapy with the same regimen. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with one of the following: a) dexamethasone, b) dexamethasone and daratumumab c) dexamethasone with bortezomib, carfilzomib, or ixazomib AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VEOZAH
Drug Names	VEOZAH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VEPPANU
Drug Names	VEPPANU
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent unresectable breast cancer
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) The disease is hormone receptor (HR)-positive, AND 2) The disease is human epidermal growth factor receptor 2 (HER2)-negative, AND 3) The disease is estrogen receptor-1 (ESR1) mutated, AND 4) The disease is advanced, metastatic, recurrent unresectable, or is unresponsive to preoperative systemic therapy, AND 5) The patient has received at least one line of endocrine therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VERKAZIA
Drug Names	VERKAZIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an ophthalmic mast cell stabilizer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VERQUVO
Drug Names	VERQUVO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For symptomatic chronic heart failure: the patient has a left ventricular ejection fraction (LVEF) less than 45 percent AND 2) the patient is receiving therapy for heart failure (for example, angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, mineralocorticoid receptor antagonist [MRA], sodium-glucose co-transporter 2 [SGLT2] inhibitor). For initial therapy, the patient meets ANY of the following: 1) hospitalization for heart failure within the past 6 months OR 2) use of outpatient intravenous diuretics for heart failure within the past 3 months.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Cobenfy, Lybalvi, Rexulti, Secuado, Vraylar.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VERZENIO
Drug Names	VERZENIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent breast cancer, endometrial cancer, in combination with letrozole for estrogen receptor positive tumor
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) the disease is either: a) advanced, recurrent, or metastatic, OR b) early breast cancer AND 2) the patient has hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease, AND 3) the requested drug will be used in combination with endocrine therapy or as a single agent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VEVYE
Drug Names	VEVYE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For signs and symptoms of dry eye disease (DED): 1) Patient has experienced an inadequate treatment response or intolerance to Restasis (cyclosporine 0.05 percent emulsion) AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VIBERZI
Drug Names	VIBERZI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VICTOZA
Drug Names	LIRAGLUTIDE, VICTOZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	For glycemic control in type 2 diabetes mellitus: 10 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VIGABATRIN
Drug Names	SABRIL, VIGABATRIN, VIGADRONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures).
Age Restrictions	Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VIGAFYDE
Drug Names	VIGAFYDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Infantile Spasms: 1 month to 2 years of age
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VIJOICE
Drug Names	VIJOICE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VIMIZIM
Drug Names	VIMIZIM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VITRAKVI
Drug Names	VITRAKVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	-
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VIVJOA
Drug Names	VIVJOA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	The patient is of reproductive potential.
Required Medical Information	To reduce the incidence of recurrent vulvovaginal candidiasis (RVVC) in a patient with a history of RVVC: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole AND 2) The requested drug will be used orally.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VIZIMPRO
Drug Names	VIZIMPRO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VONJO
Drug Names	VONJO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VOQUEZNA
Drug Names	VOQUEZNA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications except the treatment of Helicobacter pylori (H. Pylori) infection: 1) The patient has experienced an inadequate treatment response to a one-month trial each of two proton pump inhibitors (PPIs), OR 2) The patient has experienced an intolerance or has a contraindication that would prohibit a one-month trial of two PPIs. For treatment of H. pylori infection: The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) Culture and susceptibility information OR 2) Local epidemiology and susceptibility patterns.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Relief of Heartburn, Healing of EE, Maintenance of Healed EE: 6 months, H. Pylori: 14 days
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VOQUEZNA PAK
Drug Names	VOQUEZNA DUAL PAK, VOQUEZNA TRIPLE PAK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of Helicobacter pylori (H. pylori) infection: the infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	14 days
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VORANIGO
Drug Names	VORANIGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VORICONAZOLE
Drug Names	VFEND, VFEND IV, VORICONAZOLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient will use the requested drug orally or intravenously.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VOSEVI
Drug Names	VOSEVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VOTRIENT
Drug Names	PAZOPANIB HYDROCHLORIDE, VOTRIENT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, papillary, oncocytic, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor, dedifferentiated liposarcoma
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: 1) the disease is advanced, relapsed, or stage IV, OR 2) the requested drug will be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture AND 2) the patient meets one of the following: a) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib), b) the disease is succinate dehydrogenase (SDH)-deficient GIST. For soft tissue sarcoma (STS): the patient does not have an adipocytic soft tissue sarcoma.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VOWST
Drug Names	VOWST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VOXZOGO
Drug Names	VOXZOGO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For achondroplasia with open epiphyses, initial: The diagnosis is confirmed by either of the following: 1) radiological findings of characteristic features consistent with the disease OR 2) genetic testing. For achondroplasia with open epiphyses, continuation of therapy: Patient is experiencing improvement.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, geneticist, neurologist, or skeletal dysplasia specialist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VOYDEYA
Drug Names	VOYDEYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency AND 3) The requested drug is being used as add-on therapy to ravulizumab or eculizumab for the treatment of extravascular hemolysis (EVH). For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	VOYXACT
Drug Names	VOYXACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For reduction of proteinuria in patients with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VPRIV
Drug Names	VPRIV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VTAMA
Drug Names	VTAMA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis: The patient has experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial with topical corticosteroids. For atopic dermatitis: The patient meets either of the following: a) The requested drug will be used on sensitive areas (e.g., face, genitals, or skin folds) and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor, OR b) The requested drug will be used on non-sensitive (or remaining) skin areas and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor or a medium or higher potency topical corticosteroid.
Age Restrictions	AD: 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VUMERITY
Drug Names	VUMERITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYALEV
Drug Names	VYALEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For advanced Parkinson's disease: 1) Patient has inadequate treatment response or intolerance to oral carbidopa/levodopa, 2) Patient has at least 2.5 hours of daily 'off' time, AND 3) Patient is levodopa responsive with clearly defined 'on' periods. For advanced Parkinson's disease, continuation: The patient is experiencing improvement on the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	VYEPTI
Drug Names	VYEPTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYKAT XR
Drug Names	VYKAT XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hyperphagia due to Prader-Willi syndrome (initial): 1) The patient has hyperphagia (e.g., intense, persistent sensation of hunger, lack of normal satiety, food preoccupation, an extreme drive to consume food, food-related behavior problems) AND 2) The diagnosis of Prader-Willi syndrome (PWS) is confirmed by genetic testing (e.g., deletion in the chromosomal 15q11-q13 region, maternal uniparental disomy in chromosome 15, or imprinting effects, translocations, or inversions involving chromosome 15). For hyperphagia due to Prader-Willi syndrome (continuation): The patient has demonstrated a positive response to therapy (e.g., reduction in hyperphagia, reduction in body fat mass, reduced levels of leptin).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYLOY
Drug Names	VYLOY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYNDAMAX
Drug Names	VYNDAMAX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of variant or wild-type transthyretin-mediated amyloidosis (ATTR-CM), initial therapy: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by one of the following: a) imaging via echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), or b) myocardial technetium-labeled scintigraphy, AND 3) diagnosis has been confirmed by one of the following: a) biopsy confirming transthyretin amyloid deposits and presence of transthyretin precursor proteins, b) positive technetium-labeled bone scintigraphy tracing AND systemic light chain amyloidosis has been ruled out by tests showing absence of monoclonal proteins (e.g., serum kappa/lambda free light chain ratio, serum protein immunofixation, urine protein immunofixation), c) if the request is for variant ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene. For ATTR-CM, continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYNDAQEL
Drug Names	VYNDAQEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of variant or wild-type transthyretin-mediated amyloidosis (ATTR-CM), initial therapy: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by one of the following: a) imaging via echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), or b) myocardial technetium-labeled scintigraphy, AND 3) diagnosis has been confirmed by one of the following: a) biopsy confirming transthyretin amyloid deposits and presence of transthyretin precursor proteins, b) positive technetium-labeled bone scintigraphy tracing AND systemic light chain amyloidosis has been ruled out by tests showing absence of monoclonal proteins (e.g., serum kappa/lambda free light chain ratio, serum protein immunofixation, urine protein immunofixation), c) if the request is for variant ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene. For ATTR-CM, continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYSCOXA
Drug Names	VYSCOXA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic non-steroidal anti-inflammatory drug (NSAID), OR the patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VYVANSE
Drug Names	LISDEXAMFETAMINE DIMESYLA, VYVANSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic central nervous system (CNS) stimulant drug, other than lisdexamfetamine (e.g., amphetamine, dextroamphetamine, methylphenidate).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	VYVGART
Drug Names	VYVGART
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For generalized myasthenia gravis (gMG), continuation: 1) There is no evidence of unacceptable toxicity while on the current regimen AND 2) Patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	VYVGART HYTRULO
Drug Names	VYVGART HYTRULO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For generalized myasthenia gravis (gMG), continuation: 1) There is no evidence of unacceptable toxicity while on the current regimen AND 2) Patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Myasthenia gravis (MG), initial: 6 months, MG, continuation: Plan Year, All Others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	WAINUA
Drug Names	WAINUA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For polyneuropathy of hereditary transthyretin (TTR)-mediated amyloidosis, initial therapy: Patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease (for example, amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy). For polyneuropathy of hereditary TTR-mediated amyloidosis, continuation: Patient demonstrates a beneficial response to therapy (for example, improvement of neuropathy severity and rate of disease progression).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	WAKIX
Drug Names	WAKIX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. For continuation of therapy: The patient has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	WAYRILZ
Drug Names	WAYRILZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP) (new starts): Patient meets ALL of the following: 1) Patient has experienced an inadequate treatment response or is intolerant to a prior therapy (e.g., corticosteroid, immunoglobulin, thrombopoietin receptor agonist), AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation): The patient has experienced benefit from therapy (for example, increased platelet count).
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	WELIREG
Drug Names	WELIREG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	WINLEVI
Drug Names	WINLEVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to a generic acne product (e.g., topical clindamycin, topical erythromycin, topical retinoid, or oral isotretinoin).
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	WINREVAIR
Drug Names	WINREVAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	XALKORI
Drug Names	XALKORI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification, recurrent, advanced, or metastatic NSCLC with MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis, metastatic or unresectable ROS1 gene fusion positive cutaneous melanoma, metastatic or inoperable uterine sarcoma for IMT with ALK translocation
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) the patient has recurrent, advanced, or metastatic ROS-1 positive NSCLC, OR 4) the patient has NSCLC with high-level MET amplification, OR 5) the patient has recurrent, advanced, or metastatic MET exon 14 skipping mutation. For anaplastic large cell lymphoma (ALCL): 1) the disease is relapsed or refractory, AND 2) the disease is ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	XDEMVY
Drug Names	XDEMVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XELJANZ
Drug Names	TOFACITINIB CITRATE, TOFACITINIB CITRATE ER, XELJANZ, XELJANZ XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis, active ankylosing spondylitis, and active polyarticular course juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab, etanercept). For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab). For active psoriatic arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (for example, adalimumab, etanercept) AND 2) the requested drug will be used in combination with a nonbiologic DMARD.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	XEMBIFY
Drug Names	XEMBIFY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	XENPOZYME
Drug Names	XENPOZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acid sphingomyelinase deficiency (ASMD): The diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid sphingomyelinase (ASM) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XEOMIN
Drug Names	XEOMIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Cosmetic use
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XERMELO
Drug Names	XERMELO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	XHANCE
Drug Names	XHANCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Small intestinal bacterial overgrowth syndrome (SIBO)
Exclusion Criteria	-
Required Medical Information	For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug, OR 2) The patient has previously received treatment with the requested drug, AND a) the patient is experiencing a recurrence of symptoms, AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug. For small intestinal bacterial overgrowth (SIBO): 1) the patient is experiencing a recurrence after completion of a successful course of treatment with the requested drug OR 2) diagnosis has been confirmed via one of the following: a) quantitative culture of upper gut aspirate, b) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Reduction in risk of overt HE recurrence: 6 months, IBS-D and SIBO: 14 days
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XIPERE
Drug Names	XIPERE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe persistent asthma, initial therapy (tx): 1) Patient (pt) has a positive skin test (or blood test) to at least one perennial aeroallergen, 2) Pt has baseline immunoglobulin E (IgE) level greater than or equal to 30 international units per milliliter (IU/mL), AND 3) Pt has inadequate asthma control despite current tx with both of the following medications: a) Medium-to-high-dose inhaled corticosteroid, AND b) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless pt has an intolerance or contraindication to such therapies. For moderate to severe persistent asthma, continuation of tx (COT): Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms (sx) and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic spontaneous urticaria (CSU), initial tx: 1) Pt has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Pt has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Pt remains symptomatic despite H1 antihistamine treatment. For CSU, COT: Pt has experienced a benefit (e.g., improved sx) since initiation of tx. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Pt has experienced inadequate treatment response to Xhance (fluticasone). For IgE-mediated food allergy, initial tx: Pt has baseline IgE level greater than or equal to 30 IU/mL. For IgE-mediated food allergy, COT: Pt has experienced a benefit as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal sx) to food allergen.
Age Restrictions	CSU: 12 years of age or older. Asthma: 6 years of age or older. CRSwNP: 18 years of age or older. IgE-mediated food allergy: 1 year of age or older
Prescriber Restrictions	-
Coverage Duration	CSU initial: 6 months, CSU continuation, All others: Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	XOLREMDI
Drug Names	XOLREMDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis), initial: 1) Diagnosis has been confirmed via testing to detect mutations in the CXCR4 gene AND 2) The patient exhibits at least one clinical manifestation of the disease (such as warts, hypogammaglobulinemia, infections, myelokathexis) AND 3) The patient has a confirmed low neutrophil count based on the reference laboratory range or current practice guidelines. For WHIM syndrome, continuation: The patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XOSPATA
Drug Names	XOSPATA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement, acute myeloid leukemia (AML) post allogeneic hematopoietic cell transplantation (HCT), in remission.
Exclusion Criteria	-
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase. For AML with FLT3 mutation: The requested drug will be used for one of the following: a) relapsed or refractory disease, b) induction therapy, c) post-induction therapy following response to induction therapy with the requested drug, d) consolidation therapy, e) maintenance therapy in patients who are in remission after allogeneic hematopoietic cell transplantation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XPOVIO
Drug Names	XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, high-grade B-cell lymphoma, post-transplant lymphoproliferative disorders
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy. For B-cell lymphomas: Patient must have been treated with at least two lines of systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	XTANDI
Drug Names	XTANDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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

Prior Authorization Group	XYOSTED
Drug Names	XYOSTED
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	XYREM
Drug Names	SODIUM OXYBATE, XYREM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) If the patient is 18 years of age or older, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	XYWAV
Drug Names	XYWAV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient (pt) with narcolepsy, initial request: 1) The diagnosis (dx) has been confirmed by sleep lab evaluation, AND 2) If the pt is 18 years of age or older, the pt has experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For idiopathic hypersomnia, initial request, the diagnosis has been confirmed by ALL of the following: 1) Pt has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) Insufficient sleep syndrome is confirmed absent, AND 3) Cataplexy is absent, AND 4) Fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) Average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) Another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results.
Age Restrictions	Narcolepsy: 7 years of age or older, Idiopathic hypersomnia: 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	For the treatment of cataplexy in a pt with narcolepsy, initial request: The dx has been confirmed by sleep lab evaluation. For narcolepsy, continuation of therapy: The pt has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. For idiopathic hypersomnia, continuation of therapy: The pt has experienced a decrease in daytime sleepiness from baseline.
Prerequisite Therapy Required	Yes

Prior Authorization Group	YCANTH
Drug Names	YCANTH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	YERVOY
Drug Names	YERVOY
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	YESAFILI
Drug Names	YESAFILI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	YESINTEK
Drug Names	YESINTEK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	YONSA
Drug Names	YONSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	YORVIPATH
Drug Names	YORVIPATH
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Acute post-surgical hypoparathyroidism (within 6 months of surgery) and expected recovery from hypoparathyroidism
Required Medical Information	For hypoparathyroidism, initial: prior to initiation, the patient's albumin-corrected serum calcium has been or will be confirmed to be greater than or equal to 7.8 mg/dL. For hypoparathyroidism, continuation: the patient is experiencing benefit from therapy (for example, maintenance or normalization of serum calcium levels compared to baseline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	YUPELRI
Drug Names	YUPELRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following: Symbicort (budesonide/formoterol), Advair Diskus (fluticasone/salmeterol), Breo Ellipta (fluticasone/vilanterol), Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone/umeclidinium/vilanterol).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	Yes

Prior Authorization Group	YUTREPIA
Drug Names	YUTREPIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) or pulmonary hypertension (PH) associated with interstitial lung disease (WHO Group 3): the diagnosis was confirmed by right heart catheterization. For new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than 2 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	YUVIWEL
Drug Names	YUVIWEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For achondroplasia with open epiphyses (initial): The diagnosis is confirmed by either of the following: 1) radiological findings of characteristic features consistent with the disease OR 2) a pathogenic variant of the fibroblast growth factor receptor 3 (FGFR3) gene. For achondroplasia with open epiphyses (continuation): Patient is experiencing improvement.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, geneticist, neurologist, or skeletal dysplasia specialist
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZALTRAP
Drug Names	ZALTRAP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable colorectal cancer
Exclusion Criteria	-
Required Medical Information	For advanced, unresectable, or metastatic colorectal cancer (including appendiceal adenocarcinoma): the requested drug will be used in combination with FOLFIRI (fluorouracil, leucovorin, and irinotecan) or irinotecan.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZARXIO
Drug Names	ZARXIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZAVZPRET
Drug Names	ZAVZPRET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute migraine: 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to Nurtec ODT (rimegepant) OR Ubrelvy (ubrogepant).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZEJULA
Drug Names	ZEJULA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Uterine leiomyosarcoma
Exclusion Criteria	-
Required Medical Information	For uterine leiomyosarcoma: 1) the requested drug is used as second-line or subsequent therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer, hairy cell leukemia, central nervous system cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.
Exclusion Criteria	-
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant or neoadjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZELSUVMI
Drug Names	ZELSUVMI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZENBEXUS
Drug Names	ZENBEXUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZEPOSIA
Drug Names	ZEPOSIA, ZEPOSIA 7-DAY STARTER PAC, ZEPOSIA STARTER KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-bwwd, Hadlima (adalimumab-bwwd), Humira (adalimumab), Pyzchiva (usteinumab-ttwe), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Velsipity (etrasimod), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZEPZELCA
Drug Names	ZEPZELCA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed small cell lung cancer, primary progressive small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For small cell lung cancer, the patient meets either of the following: 1) the requested medication will be used as a single agent in one of the following settings: a) the disease has relapsed following complete or partial response or stable disease with initial treatment, b) the patient has primary progressive disease, or c) the patient has metastatic disease following disease progression on or after platinum-based chemotherapy, OR 2) the requested medication will be used in combination with atezolizumab or atezolizumab and hyaluronidase-tqjs AND has both of the following a) the patient has extensive-stage disease, b) the disease has not progressed following first-line induction therapy with atezolizumab or atezolizumab and hyaluronidase-tqjs, carboplatin, and etoposide.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZIEXTENZO
Drug Names	ZIEXTENZO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	-
Required Medical Information	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZIIHERA
Drug Names	ZIIHERA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For biliary tract cancer (BTC): 1) Patient has a diagnosis of unresectable, resected gross residual (R2), or metastatic, 2) Patient has received a previous treatment, 3) Patient is human epidermal growth factor receptor 2 (HER2)-positive (IHC [immunohistochemistry] 3+), AND 4) The requested drug is used as a single agent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZILBRYSQ
Drug Names	ZILBRYSQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For generalized myasthenia gravis (gMG), continuation: 1) There is no evidence of unacceptable toxicity while on the current regimen AND 2) Patient has demonstrated a positive response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZILXI
Drug Names	ZILXI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to generic topical metronidazole or generic topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of generic topical metronidazole and generic topical azelaic acid 15 percent.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

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Prior Authorization Group	ZIRABEV
Drug Names	ZIRABEV
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prerequisite Therapy Required	No

Prior Authorization Group	ZOLADEX
Drug Names	ZOLADEX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender dysphoria, treatment of chronic anovulatory uterine bleeding (CAUB) with severe anemia, ovarian cancer, fallopian tube cancer, primary peritoneal cancer, salivary gland tumors, uterine sarcoma
Exclusion Criteria	-
Required Medical Information	For breast cancer, the requested drug must be used for hormone receptor (HR)-positive disease. For gender dysphoria (GD): 1) The patient is able to make an informed decision to engage in treatment, AND 2) The patient meets ONE of the following: a) The requested drug will be used for pubertal hormonal suppression and the patient has reached Tanner stage 2 of puberty or greater, OR b) The patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones. For salivary gland tumors: 1) the disease is androgen receptor positive, AND 2) the disease is recurrent, metastatic, or unresectable. For uterine sarcoma: the requested drug will be used in combination with an aromatase inhibitor in premenopausal patients who are not suitable for surgery.
Age Restrictions	Endometriosis: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Endometrial-thinning: 3 mo. Endometriosis: max 6 mo. total. CAUB: 6 mo. Other: Plan Year
Other Criteria	The 10.8 mg strength is not approvable for diagnoses other than breast cancer or prostate cancer.
Prerequisite Therapy Required	No

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

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Prior Authorization Group	ZOLPIDEM
Drug Names	ZOLPIDEM TARTRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For insomnia: The patient has experienced an inadequate treatment response or intolerance to zolpidem immediate-release tablets.
Age Restrictions	Less than 65 years of age
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZONISADE
Drug Names	ZONISADE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	16 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZORYVE 0.05% CRM
Drug Names	ZORYVE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	2 to 5 years of age
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZORYVE 0.15%
Drug Names	ZORYVE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZORYVE 0.3% CRM
Drug Names	ZORYVE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis: The patient has experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial with topical corticosteroids.
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZORYVE FOAM
Drug Names	ZORYVE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For seborrheic dermatitis: If the patient is 12 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to topical ketoconazole. For plaque psoriasis: The patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	Seborrheic Dermatitis: 9 years of age or older, Plaque Psoriasis: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZTALMY
Drug Names	ZTALMY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZUNVEYL
Drug Names	ZUNVEYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to galantamine.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZURZUVAE
Drug Names	ZURZUVAE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Small lymphocytic lymphoma (SLL)
Exclusion Criteria	-
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL): the requested drug is used as second-line or subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), brain metastases from ALK-positive NSCLC, relapsed or refractory ALK-positive anaplastic large cell lymphoma (ALCL)
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) ROS1-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	Yes

Prior Authorization Group	ZYNLONTA
Drug Names	ZYNLONTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Human immunodeficiency virus (HIV)-related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesviruse-8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified) and histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZYNYZ
Drug Names	ZYNYZ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Colorectal cancer, small bowel adenocarcinoma, appendiceal adenocarcinoma
Exclusion Criteria	-
Required Medical Information	For Merkel cell carcinoma: the disease is metastatic, locally advanced, or recurrent. For colorectal cancer, small bowel adenocarcinoma, and appendiceal adenocarcinoma: the disease has deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No

Prior Authorization Group	ZYPREXA RELPREVV
Drug Names	ZYPREXA RELPREVV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prerequisite Therapy Required	No