KAISER PERMANENTE®

Kaiser Permanente Medicare Advantage HMO

2024 Prior Authorization Requirements

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

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

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

Formulary ID 00024409 Version 22 Last updated: 06/2024

Prior Authorization Criteria
Kaiser Washington
Effective: 07/01/2024

ABATACEPT

Products Affected

- Orencia
- Orencia Clickject

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ABRILADA

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ABROCITINIB

Products Affected

- Cibinqo

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

ACALABRUTINIB (NEW STARTS ONLY)

Products Affected

- Calquence CAPS

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

ADALIMUMAB

Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	For patients with moderate to severe plaque psoriasis, rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, and ulcerative colitis who have failure, contraindication, or intolerance to adalimumab-atto (Amjevita). Covered for uveitis and hidradenitis suppurativa.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

AKEEGA (NEW STARTS ONLY)

Products Affected

- Akeega

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ALECTINIB (NEW STARTS ONLY)

Products Affected

- Alecensa

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

ALPELISIB (NEW STARTS ONLY)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HR-positive and HER2-negative, documentation of PIK3CA mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for men or postmenopausal women with metastatic or advanced breast cancer that is PIK3CA mutated and HER2 negative, in combination with fulvestrant after disease progression on or after endocrine-based therapy.

AMIFAMPRIDINE PHOSPHATE

Products Affected

- Firdapse

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

AMIKACIN LIPOSOMAL

Products Affected

- Arikayce

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

AMJEVITA

Products Affected

- Amjevita

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ANAKINRA

Products Affected

- Kineret

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

APREMILAST

Products Affected

- Otezla

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

ARMODAFINIL

Products Affected

- Armodafinil

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ASENAPINE (NEW STARTS ONLY)

Products Affected

- Asenapine Maleate Sl
- Secuado

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ATOGEPANT

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients who have 1) failure, contraindication, or intolerance to at least one preferred preventative agents including topiramate, valproic acid and derivatives, and beta-blocker and, 2) documentation of an adequate trial and failure fremanezumab-vfrm (Ajovy). An adequate trial is defined as at least 2 months of maximally tolerated dose or documented intolerance or contraindication. Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm).

AVACOPAN

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Positive test for anti-PR3 or anti-MPO (proteinase 3 or myeloperoxidase antibodies) or positive tissue biopsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with clinical diagnosis of ANCA vasculitis GPA or MPA, or ANCA-positive vasculitis who have a history of significant intolerance to steroid or relative contraindication to steroid per prescriber judgement (factoring in comorbidities and other clinical considerations), or require a decrease in cumulative steroid dose due to steroid-induced complications.

AVONEX

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

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

AXITINIB (NEW STARTS ONLY)

Products Affected

- Inlyta

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

AZTREONAM INHALATION

Products Affected

- Cayston

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

BARICITINIB

Products Affected

- Olumiant TABS 1MG, 2MG

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BELUMOSUDIL

Products Affected

- Rezurock

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

BENRALIZUMAB

Products Affected

- Fasenra INJ 30MG/ML
- Fasenra Pen

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

BEREMAGENE GEPERPAVEC-SVDT

Products Affected

- Vyjuvek

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BEROTRALSTAT

Products Affected

- Orladeyo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BEXAROTENE (NEW STARTS ONLY)

Products Affected

- Bexarotene GEL

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BIMEKIZUMAB-BKZX

Products Affected

- Bimzelx

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

BINIMETINIB (NEW STARTS ONLY)

Products Affected

- Mektovi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BIRCH TRITERPENES

Products Affected

- Filsuvez

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

BOSUTINIB (NEW STARTS ONLY)

Products Affected

- Bosulif

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BOTULINUM TOXIN

Products Affected

- Xeomin INJ 200UNIT

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BREXPIPRAZOLE (NEW STARTS ONLY)

Products Affected

- Rexulti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) major depression disorder as adjunctive or add-on treatment to antidepressant therapy who have failure, contraindication or intolerance to aripiprazole and one antidepressant, or 2) schizophrenia who have failure, contraindication or intolerance to at least two other antipsychotics (i.e., risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole), or 3) agitation associated with dementia due to Alzherimer's disease who have failure, contraindication or intolerance to at least two other antipsychotics.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

BRODALUMAB

Products Affected

- Siliq

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

BUROSUMAB-TWZA

Products Affected

- Crysvita

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CABOMETYX (NEW STARTS ONLY)

Products Affected

- Cabometyx

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

CALCIUM, MAGNESIUM, POTASSIUM, AND SODIUM OXYBATE

Products Affected

- Xywav

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physician board certified in sleep disorders.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with narcolepsy with cataplexy, or 2) with excessive daytime sleepiness in narcolepsy who have contraindication, intolerance or failure to modafinil or armodafinil and another formulary stimulant, or 3) idiopathic hypersomnia.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CANNABIDIOL (NEW STARTS ONLY)

Products Affected

- Epidiolex

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

CARIPRAZINE (NEW STARTS ONLY)

Products Affected

- Vraylar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	For acute treatment of bipolar mania or mixed episodes associated with bipolar I disorder, patients must have failure, contraindication, or intolerance to two preferred antipsychotics (e.g., risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole). For depressive episodes associated with bipolar I and II disorder, patient must have failure, intolerance, or contraindication to one mood stabilizer (e.g., lithium, lamotrigine, divalproex) and either quetiapine or olanzapine. For schizophrenia, patient must have failure, intolerance, or contraindication to two of the following: risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole.

CASIMERSEN

Products Affected

- Amondys 45

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

CENOBAMATE (NEW STARTS ONLY)

Products Affected

- Xcopri

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CERITINIB (NEW STARTS ONLY)

Products Affected

- Zykadia

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

CERTOLIZUMAB

Products Affected

- Cimzia
- Cimzia Starter Kit

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CHORIONIC GONADOTROPIN

Products Affected

- Chorionic Gonadotropin INJ

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CLADRIBINE (NEW STARTS ONLY)

Products Affected

- Mavenclad

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

COMETRIQ (NEW STARTS ONLY)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for treatment of symptomatic or progressive medullary thyroid cancer (MTC) in patients with unresectable locally advanced or metastatic disease and the patients have failure, contraindication, or intolerance to vandetanib due to a history of QT prolongation, Torsades de Pointes, or concurrent use of QT prolonging drug.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CORTICOTROPIN

Products Affected

- Acthar
- Cortrophin

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CRIZANLIZUMAB-TMCA

Products Affected

- Adakveo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CRIZOTINIB (NEW STARTS ONLY)

Products Affected

- Xalkori

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

CYLTEZO

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

CYSTEAMINE DELAYED-RELEASE

Products Affected

- Procysbi

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

CYSTEAMINE OPHTHALMIC

Products Affected

- Cystadrops
- Cystaran

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DABRAFENIB (NEW STARTS ONLY)

Products Affected

- Tafinlar

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DASATINIB (NEW STARTS ONLY)

Products Affected

- Sprycel

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DEFLAZACORT

Products Affected

- Deflazacort
- Emflaza

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DENOSUMAB

Products Affected

- Xgeva

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DEUTETRABENAZINE

Products Affected

- Austedo
- Austedo Xr TB24 12MG, 24MG, 6MG
- Austedo Xr Patient Titration Kit

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DICHLORPHENAMIDE

Products Affected

- Dichlorphenamide
- Keveyis
- Ormalvi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DIROXIMEL FUMARATE

Products Affected

- Vumerity

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

DROXIDOPA

Products Affected

- Droxidopa

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

DUPILUMAB

Products Affected

- Dupixent

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

EDARAVONE

Products Affected

- Radicava
- Radicava Ors
- Radicava Ors Starter Kit

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ENASIDENIB (NEW STARTS ONLY)

Products Affected

- Idhifa

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

EPCLUSA BRAND

Products Affected

- Epclusa

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

EPLONTERSEN

Products Affected

- Wainua

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ESKETAMINE (NEW STARTS ONLY)

Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ETANERCEPT

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	For moderate to severe plaque psoriasis, covered for patients who have failure, contraindication, or intolerance to adalimumab. Covered for rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, psoriatic arthritis, and ankylosing spondylitis.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ETEPLIRSEN

Products Affected

- Exondys 51

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

EVOLOCUMAB

Products Affected

- Repatha Sureclick

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

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

FENTANYL TRANSMUCOSAL

Products Affected

- Fentanyl Citrate TABS
- Lazanda SOLN 100MCG/ACT, 400MCG/ACT
- Subsys LIQD 1200MCG, 1600MCG

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

FERRIC CITRATE

Products Affected

- Auryxia

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

FINGOLIMOD (NEW STARTS ONLY)

Products Affected

- Gilenya CAPS 0.25MG
- Tascenso Odt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for 1) patients 10 to 17 years of age with a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, or 2) patients 18 years of age or older with a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to two or more of the following: interferon beta-1b (e.g., Extavia, Betaseron), glatiramer (Glatopa), dimethyl fumarate, or natalizumab, of which one of the disease-modifying therapy must be dimethyl fumarate. Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

FREMANEZUMAB-VFRM

Products Affected

- Ajovy

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

GIVOSIRAN

Products Affected

- Givlaari

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

GOLIMUMAB

Products Affected

- Simponi
- Simponi Aria

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

GOLODIRSEN

Products Affected

- Vyondys 53

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

GUSELKUMAB

Products Affected

- Tremfya

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

HADLIMA

Products Affected

- Hadlima
- Hadlima Pushtouch

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

HARVONI BRAND

Products Affected

- Harvoni

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

HULIO

Products Affected

- Hulio

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

HYRIMOZ

Products Affected

- Adalimumab-adaz
- Hyrimoz
- Hyrimoz Crohn's Disease And Ulcerative Colitis Starter Pack
- Hyrimoz Pediatric Crohns Disease Starter Pack
- Hyrimoz Pediatric Crohn'sdisease Starter Pack
- Hyrimoz Plaque Psoriasis Starter Pack
- Hyrimoz Sensoready Pens

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ICOSAPENT ETHYL

Products Affected

- Icosapent Ethyl

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

IDACIO

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

INOTERSEN

Products Affected

- Tegsedi

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

IVACAFTOR

Products Affected

- Kalydeco

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

IXAZOMIB (NEW STARTS ONLY)

Products Affected

- Ninlaro

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

IXEKIZUMAB

Products Affected

- Taltz

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

LAROTRECTINIB (NEW STARTS ONLY)

Products Affected

- Vitrakvi

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

LEDIPASVIR/SOFOSBUVIR

Products Affected

- Ledipasvir/sofosbuvir

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LENIOLISIB

Products Affected

- Joenja

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LENVATINIB (NEW STARTS ONLY)

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

L-GLUTAMINE

Products Affected

- Endari

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LIDOCAINE TRANSDERMAL

Products Affected

- Lidocaine PTCH 5%
- Lidocan

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LIRAGLUTIDE

Products Affected

- Victoza

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LOFEXIDINE

Products Affected

- Lucemyra

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

LOMITAPIDE

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of homozygous familial hypercholesterolemia who had inadequate response (less than 50% reduction in LDL or LDL greater than 130 mg/dL) or intolerability to maximum tolerated doses of rosuvastatin in combination with ezetimibe or PCSK9 inhibitor (e.g., evolocumab).

LONAFARNIB

Products Affected

- Zokinvy

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LONAPEGSOMATROPIN-TCGD

Products Affected

- Skytrofa

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LUMACAFTOR/IVACAFTOR

Products Affected

- Orkambi

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

LUMASIRAN

Products Affected

- Oxlumo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LUMATEPERONE (NEW STARTS ONLY)

Products Affected

- Caplyta

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

LUSPATERCEPT-AAMT

Products Affected

- Reblozyl

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MANNITOL

Products Affected

- Bronchitol

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MARALIXIBAT

Products Affected

- Livmarli

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MAVACAMTEN

Products Affected

- Camzyos

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

MAVYRET

Products Affected

- Mavyret

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MEPOLIZUMAB

Products Affected

- Nucala

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

METOCLOPRAMIDE NASAL

Products Affected

- Gimoti

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MIFEPRISTONE 300MG

Products Affected

- Korlym

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MIRIKIZUMAB-MRKZ

Products Affected

- Omvoh

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MITAPIVAT

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MODAFINIL

Products Affected

- Modafinil TABS

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

MONOMETHYL FUMARATE

Products Affected

- Bafiertam

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

NATPARA

Products Affected

- Natpara

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

NEDOSIRAN

Products Affected

- Rivfloza

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

NERATINIB (NEW STARTS ONLY)

Products Affected

- Nerlynx

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

NINTEDANIB

Products Affected

- Ofev

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

NIRAPARIB (NEW STARTS ONLY)

Products Affected

- Zejula

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

NUEDEXTA

Products Affected

- Nuedexta

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ODEVIXIBAT

Products Affected

- Bylvay
- Bylvay (pellets)

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OFATUMUMAB

Products Affected

- Kesimpta

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

OLAPARIB (NEW STARTS ONLY)

Products Affected

- Lynparza TABS

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OMALIZUMAB

Products Affected

- Xolair

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

OMAVELOXOLONE

Products Affected

- Skyclarys

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OPSYNVI

Products Affected

- Opsynvi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OSILODROSTAT

Products Affected

- Isturisa

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OSIMERTINIB (NEW STARTS ONLY)

Products Affected

- Tagrisso

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

OZANIMOD (NEW STARTS ONLY)

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or gastroenterologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to two or more of the following: interferon beta-1b (e.g., Extavia, Betaseron), glatiramer (Glatopa), dimethyl fumarate, or natalizumab, of which one of the disease-modifying therapy must be dimethyl fumarate. Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage, or 2) moderate to severe ulcerative colitis who have failure, contraindication, or intolerance to at least one preferred anti-TNF (infliximab, adalimumab) and ustekinumab. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PALBOCICLIB (NEW STARTS ONLY)

Products Affected

- Ibrance

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PAROXETINE (NEW STARTS ONLY)

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PATISIRAN

Products Affected

- Onpattro

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

PEGVALIASE-PQPZ

Products Affected

- Palynziq

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PERAMPANEL (NEW STARTS ONLY)

Products Affected

- Fycompa

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PIMAVANSERIN (NEW STARTS ONLY)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PIRFENIDONE

Products Affected

- Pirfenidone

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

PITOLISANT

Products Affected

- Wakix

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PLEGRIDY

Products Affected

- Plegridy
- Plegridy Starter Pack

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

POMALIDOMIDE (NEW STARTS ONLY)

Products Affected

- Pomalyst

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PONESIMOD (NEW STARTS ONLY)

Products Affected

- Ponvory
- Ponvory 14-day Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with 1) a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to two or more of the following: interferon beta-1b (e.g., Extavia, Betaseron), glatiramer (Glatopa), dimethyl fumarate, or natalizumab, of which one of the disease-modifying therapy must be dimethyl fumarate. Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PROGESTERONE

Products Affected

- Endometrin

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

REBIF

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

REGORAFENIB (NEW STARTS ONLY)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with 1) advanced hepatocellular carcinoma (HCC) and Child-Pugh Class A liver function status who have progressed on or after sorafenib Treatment of adult patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy, or 2) metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild- type, an anti-EGFR therapy, or 3) locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate and sunitinib malate.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RELUGOLIX (NEW STARTS ONLY)

Products Affected

- Orgovyx

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RESMETIROM

Products Affected

- Rezdiffra

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RIMEGEPANT

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	One year
Other Criteria	Covered for patients 1) with acute treatment of migraine who have failure, contraindication, or intolerance to at least one oral triptans at maximally tolerated doses and ubrogepant. Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant, atogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm). or 2) for the preventative treatment of episodic migraine who have failure, contraindication, or intolerance to atogepant and fremanezumab-vfrm (Ajovy). Not covered for concomitant use with other small molecule CGRP agents (e.g. ubrogepant, atogepant) or monoclonal CGRP agents (e.g. fremanezumab-vfrm).

RIOCIGUAT

Products Affected

- Adempas

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

RISANKIZUMAB-RZAA

Products Affected

- Skyrizi
- Skyrizi Pen

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RISDIPLAM

Products Affected

- Evrysdi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RITLECITINIB

Products Affected

- Litfulo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RUCAPARIB (NEW STARTS ONLY)

Products Affected

- Rubraca

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

RUXOLITINIB (NEW STARTS ONLY)

Products Affected

- Jakafi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SARILUMAB

Products Affected

- Kevzara

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SATRALIZUMAB-MWGE

Products Affected

- Enspryng

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documented positive anti-aquaporin-4 (APQ4) antibody.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a multiple sclerosis specialist, ophthalmologist or neurologist.
Coverage Duration	One year
Other Criteria	N/A

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SECUKINUMAB

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with moderate to severe plaque psoriasis, psoriatic arthritis, enthesitis-related arthritis (ERA), ankylosing spondylitis or active non-radiographic axial spondyloarthritis (nraxSpA) who have failure, intolerance, or contraindication to one anti-TNF agent (i.e., adalimumab, infliximab).

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SELEXIPAG

Products Affected

- Uptravi
- Uptravi Titration Pack

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SELPERCATINIB (NEW STARTS ONLY)

Products Affected

- Retevmo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SEMAGLUTIDE

Products Affected

- Ozempic

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SILDENAFIL

Products Affected

- Liqrev
- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SIMLANDI

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SIPONIMOD (NEW STARTS ONLY)

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of relapsing form of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease who have failure, contraindication, or intolerance to two or more of the following: interferon beta-1b (e.g., Extavia, Betaseron), glatiramer (Glatopa), dimethyl fumarate, or natalizumab, of which one of the disease-modifying therapy must be dimethyl fumarate. Minor injection site reactions alone are not considered medication failure or intolerance qualified for coverage. Part B before Part D Step Therapy. Applies only to beneficiaries in a MAPD plan.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine Hydrochloride TABS 10MG, 5MG
- Methocarbamol TABS 500MG, 750MG

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

SODIUM OXYBATE

Products Affected

- Lumryz
- Sodium Oxybate

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SODIUM OXYBATE BRAND

Products Affected

- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or physician board certified in sleep disorders.
Coverage Duration	One year
Other Criteria	Covered for 1) patients with narcolepsy with cataplexy, or 2) adult patients with excessive daytime sleepiness in narcolepsy who have contraindication, intolerance or failure to modafinil or armodafinil and generic sodium oxybate, or 3) pediatric patients 7 years of age and older with excessive daytime sleepiness in narcolepsy who have contraindication, intolerance or failure to generic sodium oxybate and another formulary stimulant.

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SODIUM PHENYLBUTYRATE/TAURURSODIOL

Products Affected

- Relyvrio

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SODIUM ZIRCONIUM CYCLOSILICATE

Products Affected

- Lokelma

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SOFOSBUVIR

Products Affected

- Sovaldi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SOFOSBUVIR/VELPATASVIR

Products Affected

- Sofosbuvir/velpatasvir

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SOMAPACITAN-BECO

Products Affected

- Sogroya

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SOMATROPIN

Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Humatrope Combo Pack
- Norditropin Flexpro
- Omnitrope
- Zorbtive

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SONIDEGIB (NEW STARTS ONLY)

Products Affected

- Odomzo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SORAFENIB (NEW STARTS ONLY)

Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SPARSENTAN

Products Affected

- Filspari

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SUTIMLIMAB-JOME

Products Affected

- Enjaymo

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

SYMDEKO

Products Affected

- Symdeko

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TADALAFIL

Products Affected

- Tadalafil TABS 2.5MG, 5MG

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

TADALAFIL (PAH)

Products Affected

- Tadalafil TABS 20MG
- Tadliq

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TAFAMIDIS

Products Affected

- Vyndamax
- Vyndaqel

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TAPINAROF

Products Affected

- Vtama

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TASIMELTEON

Products Affected

- Hetlioz Lq
- Tasimelteon

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TEDUGLUTIDE

Products Affected

- Gattex

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TENAPANOR

Products Affected

- Ibsrela
- Xphozah

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TEPROTUMUMAB-TRBW

Products Affected

- Tepezza

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TEZEPELUMAB-EKKO

Products Affected

- Tezspire

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TILDRAKIZUMAB-ASMN

Products Affected

- Ilumya

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOBRAMYCIN INHALATION BRAND

Products Affected

- Kitabis Pak
- Tobi Podhaler

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOBRAMYCIN INHALATION GENERIC

Products Affected

- Tobramycin NEBU

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOCILIZUMAB

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One year
Other Criteria	Covered for patients with rheumatoid arthritis who have tried and failed one of the following agents (adalimumab, etanercept). Covered for patients with active systemic juvenile idiopathic arthritis or polyarticular juvenile idiopathic arthritis or giant cell arteritis or systemic sclerosis-associated interstitial lung disease (SSc-ILD).

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOCILIZUMAB-AAZG

Products Affected

- Tyenne

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOCILIZUMAB-BAVI

Products Affected

- Tofidence

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOFACITINIB

Products Affected

- Xeljanz TABS
- Xeljanz Xr

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOFACITINIB ORAL SOLUTION

Products Affected

- Xeljanz SOLN

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TOREMIFENE (NEW STARTS ONLY)

Products Affected

- Toremifene Citrate

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TRALOKINUMAB-LDRM

Products Affected

- Adbry

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

TRAMETINIB (NEW STARTS ONLY)

Products Affected

- Mekinist

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TRICYCLIC ANTIDEPRESSANTS (NEW STARTS ONLY)

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TRIKAFTA

Products Affected

- Trikafta

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

TROFINETIDE

Products Affected

- Daybue

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

UBROGEPANT

Products Affected

- Ubrelvy

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

UPADACITINIB

Products Affected

- Rinvoq

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

USTEKINUMAB

Products Affected

- Stelara

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VALBENAZINE

Products Affected

- Ingrezza

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VAMOROLONE

Products Affected

- Agamree

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VEDOLIZUMAB

Products Affected

- Entyvio INJ 108MG/0.68ML

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

VENETOCLAX (NEW STARTS ONLY)

Products Affected

- Venclexta
- Venclexta Starting Pack

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VIEKIRA PAK

Products Affected

- Viekira Pak

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

VILAZODONE (NEW STARTS ONLY)

Products Affected

- Viibryd Starter Pack
- Vilazodone Hydrochloride

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VILTOLARSEN

Products Affected

- Viltepso

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

VISMODEGIB (NEW STARTS ONLY)

Products Affected

- Erivedge

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VORTIOXETINE (NEW STARTS ONLY)

Products Affected

- Trintellix

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VOSEVI

Products Affected

- Vosevi

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

VOSORITIDE

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Bone age is 14 or greater for female or 16 or greater for males.
Required Medical Information	Diagnosis of achondroplasia has been confirmed by genetic testing, with documentation of a mutation in the fibroblast growth factor receptor 3 (FGFR3) gene, Clinical evidence of open growth plates (open epiphyses).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist or endocrinologist.
Coverage Duration	One year
Other Criteria	N/A

VUTRISIRAN

Products Affected

- Amvuttra

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

YUFLYMA

Products Affected

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

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

YUSIMRY

Products Affected

- Yusimry

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ZANUBRUTINIB (NEW STARTS ONLY)

Products Affected

- Brukinsa

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ZAVEGEPANT

Products Affected

- Zavzpret

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ZEPATIER

Products Affected

- Zepatier

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ZILEUTON

Products Affected

- Zileuton Er

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

ZILUCOPLAN

Products Affected

- Zilbrysq

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

PART B VERSUS PART D

Products Affected

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

Details

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

Formulary ID: 24409, Version: 22, Effective Date: 07/01/2024
Last Updated: June 2024

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

Index Of Drugs

C

D

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

E

F

G

H

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

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

N

O

P

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

Q

R

S

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

T

U

V

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

W

X

Y

Z