VNSNY CHOICE Total

Prior Authorization Requirements

Effective: 01/01/2022
# ABALOPARATIDE

**Products Affected**
- TYMLOS

## Exclusion Criteria

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<tr>
<th>PA Criteria</th>
<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>POSTMENOPAUSAL OSTEOPOROSIS: PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.</td>
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## Required Medical Information

<table>
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<tr>
<th>Timeframe</th>
<th>Details</th>
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<tbody>
<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
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## Age Restrictions

None specified.

## Prescriber Restrictions

None specified.
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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Other Criteria</td>
<td>POSTMENOPAUSAL OSTEOPOROSIS: ONE OF THE FOLLOWING: 1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S), B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. 2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). 3) TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO ONE BISPHOSPHONATE.</td>
</tr>
</tbody>
</table>

**Indications**

All FDA-approved Indications.

**Off Label Uses**


# ABATACEPT IV

## Products Affected

- ORENCIA (WITH MALTOSE)

## PA Criteria | Criteria Details
--- | ---
Exclusion Criteria | 
Required Medical Information | 
Age Restrictions | 
Prescriber Restrictions | RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria | INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ. RENEWAL: RA, PJIA, PSA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications | All FDA-approved Indications.
Off Label Uses | 

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# ABATACEPT SQ

**Products Affected**

- ORENCIA
- ORENCIA CLICKJECT

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<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.</td>
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## ABEMACICLIB

### Products Affected
- VERZENIO

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<td>THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY.</td>
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# ABIRATERONE

## Products Affected
- abiraterone
- ZYTIGA

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<td><strong>Other Criteria</strong></td>
<td>METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.</td>
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# ABIRATERONE SUBMICRONIZED

## Products Affected
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<td>Coverage Duration</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: PHYSICIAN ATTESTATION THAT THE PATIENT CANNOT USE THE FORMULARY PREFERRED AGENT ZYTIGA (ABIRATERONE ACETATE) AND ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.</td>
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ACALABRUTINIB

Products Affected
- CALQUENCE

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<td>Other Criteria</td>
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<td>Indications All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# ADALIMUMAB

## Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

## PA Criteria

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<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.</td>
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<tr>
<td><strong>Required Medical Information</strong></td>
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<tr>
<td>RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST.</td>
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<td><strong>Age Restrictions</strong></td>
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<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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## Coverage Duration

<p>| INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |</p>
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<tbody>
<tr>
<td>Other Criteria</td>
<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLПREDNISOLONЕ), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td>Off Label Uses</td>
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# AFATINIB DIMALEATE

## Products Affected
- GILOTRIF

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# AGALSIDASE BETA

## Products Affected
- FABRAZYME

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<td><strong>Required Medical Information</strong></td>
<td>INITIAL: FABRY DISEASE: PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.</td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>FABRY DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>FABRY DISEASE: INITIAL: PATIENT IS NOT CONCURRENTLY USING AN ALPHA-GAL A PHARMACOLOGICAL CHAPERONE (I.E., GALAFOLD (MIGALASTAT)), RENEWAL: PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.</td>
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<tr>
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<tr>
<td><strong>Off Label Uses</strong></td>
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# ALECTINIB

**Products Affected**

- ALECENSA

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### ALPELISIB

#### Products Affected
- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X 1-50 MG X 1), 300 MG/DAY (150 MG X 2)

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# AMIVANTAMAB-VMJW

**Products Affected**
- RYBREVANT

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<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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**ANAKINRA**

Products Affected

- **KINERET**

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<td>Indications</td>
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# APALUTAMIDE

## Products Affected
- ERLEADA

## PA Criteria

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## Indications
All FDA-approved Indications.

## Off Label Uses
# APOMORPHINE

## Products Affected
- APOKYN

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<td>PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.</td>
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<td>PD: INITIAL: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: PATIENT HAD IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF APOKYN.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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# APOMORPHINE - SL

## Products Affected
- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

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<td>Other Criteria</td>
<td>INITIAL: PD: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: PD: PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF KYNMOBI.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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## APREMILAST

### Products Affected
- OTEZLA
- OTEZLA STARTER

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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
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**Indications**

All FDA-approved Indications.

**Off Label Uses**
ASCIMINIB

Products Affected
• SCEMBLIX

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<td>Off Label Uses</td>
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## ASFOTASE

### Products Affected
- STRENSIQ

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<td>Age Restrictions</td>
<td>PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.</td>
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<td>Other Criteria</td>
<td>INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-</td>
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<td>PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK</td>
<td>3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE</td>
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<tr>
<td>RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOGENIA, OSTEOALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS)</td>
<td>4.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES), PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.</td>
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ASPARAGINASE

Products Affected
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ATEZOLIZUMAB

Products Affected
• TECENTRIQ

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AVAPRITINIB

Products Affected
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# AVATROMBOPAG

## Products Affected
- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

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<td>CHRONIC LIVER DISEASE (CLD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.</td>
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<td>CLD: INITIAL: PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC ITP: INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: PATIENT HAD A CLINICAL RESPONSE.</td>
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### AVELUMAB

**Products Affected**
- BAVENCIO

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# AXITINIB

## Products Affected
- INLYTA ORAL TABLET 1 MG, 5 MG

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AZACITIDINE

Products Affected
• ONUREG

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AZTREONAM LYSINE

Products Affected
• CAYSTON

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BARICITINIB

Products Affected

• OLMUMIANT

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## BECAPLERMIN

### Products Affected
- REGRANEX

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<td>PRESCRIBED BY OR IN CONSULTATION WITH A VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.</td>
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## BEDAQUILINE FUMARATE

### Products Affected
- SIRTURO

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<td>SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.</td>
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# BELANTAMAB MAFODOTIN-BLMF

## Products Affected
- BLENREP

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## BELIMUMAB

### Products Affected
- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

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<td>SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.</td>
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<td>INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: CLINICAL IMPROVEMENT IN RENAL RESPONSE COMPARED TO BASELINE OR CLINICAL PARAMETERS (E.G., FLUID RETENTION, USE OF RESCUE DRUGS, GLUCOCORTICOID DOSE).</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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## BELINOSTAT

### Products Affected
- **BELEODAQ**

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# BELUMOSUDIL MESYLATE

## Products Affected
- REZUROCK

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# BELZUTIFAN

**Products Affected**
- WELIREG

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## BENDAMUSTINE

### Products Affected
- BENDEKA
- TREANDA

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**BENRALIZUMAB**

**Products Affected**
- FASENRA
- FASENRA PEN

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## Products Affected
- ORLADEYO

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BEVACIZUMAB

Products Affected
• AVASTIN

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<td>TRIAL OF OR CONTRAINIDCATION TO ZIRABEV WHERE INDICATIONS ALIGN. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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## BEVACIZUMAB-AWWB

### Products Affected
- MVASI

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# BEVACIZUMAB-BVZR

## Products Affected
- ZIRABEV

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# BEXAROTENE

## Products Affected
- bexarotene
- TARGRETIN TOPICAL

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BINIMETINIB

Products Affected
- MEKTOVI

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# BLINATUMOMAB

**Products Affected**
- BLINCYTO INTRAVENOUS KIT

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<td>INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.</td>
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<td>INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL; APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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# BORTEZOMIB

## Products Affected
- BORTEZOMIB
- VELCADE

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# BOSUTINIB

## Products Affected
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

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<td>CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT T315I, V299L, G250E, OR F317L MUTATIONS ARE NOT PRESENT.</td>
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## Age Restrictions

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## Off Label Uses

54
# BRENTUXIMAB

**Products Affected**

- ADCETRIS

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BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS, DOSE PACK

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C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

Products Affected
- CINRYZE

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C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

Products Affected
• HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT

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# CABOZANTINIB

## Products Affected
- COMETRIQ

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# CABOZANTINIB S-MALATE - CABOMETYX

**Products Affected**
- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

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## CALASPARGASE PEGOL-MKNL

### Products Affected
- ASPARLAS

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# CANAKINUMAB

## Products Affected
- ILARIS (PF)

## PA Criteria

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<tr>
<td>Prescriber Restrictions</td>
<td>CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA), ADULT-ONSET STILL DISEASE (AOSD): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: AOSD, SJIA: 6 MONTHS. INITIAL: ALL OTHER INDICATIONS: 12 MONTHS. RENEWAL: AOSD, SJIA: 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: AOSD, SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUGS). RENEWAL: AOSD, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td>Indications</td>
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<td>Off Label Uses</td>
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# CANNABIDIOL

## Products Affected
- EPIDIOLEX

## Exclusion Criteria
- DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC):
  - PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

## Required Medical Information

## Age Restrictions

## Prescriber Restrictions
- DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC):
  - PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

## Coverage Duration
- INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.

## Other Criteria
- INITIAL: LENNOX-GASTAUT SYNDROME (LGS):
  - TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING:
    - CLOBAZAM, TOPIRAMATE, LAMOTRIGINE.
  - RENEWAL: DS, LGS, TSC:
    - CONFIRMATION OF DIAGNOSIS.

## Indications
- All FDA-approved Indications.

## Off Label Uses
## CAPLACIZUMAB YHDP

### Products Affected
- CABLIVI INJECTION KIT

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<td>PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST</td>
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<td>Coverage Duration</td>
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<tr>
<td>Other Criteria</td>
<td>CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).</td>
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<tr>
<td>Indications</td>
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## CAPMATINIB

### Products Affected
- TABRECTA

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CARFILZOMIB

Products Affected

- KYPROLIS

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## CEMIPLIMAB

### Products Affected
- LIBTAYO

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# CERITINIB

**Products Affected**
- ZYKADIA ORAL TABLET

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CERTOLIZUMAB PEGOL

Products Affected
- CIMZIA
- CIMZIA POWDER FOR RECONST

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<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ. PSO: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. AS: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CD: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO 1) THE FOLLOWING PREFERRED AGENT: COSENTYX, AND 2) AN NSAID. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS. RENEWAL: RA, PSA, AS, PSO, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<th>Indications</th>
<th>All FDA-approved Indications.</th>
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## CETUXIMAB

### Products Affected
- ERBITUX

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<td><strong>Coverage Duration</strong></td>
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<tr>
<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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**CLADRIBINE**

**Products Affected**
- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

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<td>RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.</td>
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# CLOBAZAM

## Products Affected
- *clobazam oral suspension*
- *clobazam oral tablet*

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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.</td>
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# CLOBAZAM-SYMPAZAN

## Products Affected
- SYMPAZAN

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<td><strong>Coverage Duration</strong></td>
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<td><strong>Other Criteria</strong></td>
<td>LENNOX-GASTAUT SYNDROME (LGS): 1) PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.</td>
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<td><strong>Indications</strong></td>
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### COBIMETINIB FUMARATE

**Products Affected**
- COTELLIC

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**COLCHICINE**

**Products Affected**
- *colchicine oral tablet*

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<td>PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER</td>
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<td>TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) WHERE INDICATIONS ALIGN.</td>
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COPANLISIB DI-HCL

Products Affected
- ALIQOPA

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# CORTICOTROPIN

**Products Affected**
- ACTHAR

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<tr>
<td>Prescriber Restrictions</td>
<td>ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.</td>
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<td>INFANTILE SPASMS AND MS: 28 DAYS, OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: TRIAL OF OR CONTRAINDICATION TO A STANDARD OF CARE THERAPY. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 1) DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS, AND 2) CONTINUES TO POSSESS CONTRAINDICATION TO IV CORTICOSTEROIDS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.</td>
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CRIZANLIZUMAB-TMCA

Products Affected

- ADAKVEO

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<td>Prescriber Restrictions</td>
<td>SICKLE CELL DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST</td>
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<td>Coverage Duration</td>
<td>INITIAL: 12 MONTHS. RENEWAL: LIFETIME</td>
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<td>SICKLE CELL DISEASE: INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PATIENT HAS ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISSES IN THE PAST YEAR, (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 16 TO 17 YEARS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.</td>
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Indications

- All FDA-approved Indications.

Off Label Uses
# CRIZOTINIB

## Products Affected
- XALKORI

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### CYSTEAMINE HYDROCHLORIDE

**Products Affected**
- CYSTADROPS
- CYSTARAN

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DABRAFENIB MESYLATE

Products Affected
• TAFINLAR

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# DACOMITINIB

## Products Affected
- VIZIMPRO

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**DALFAMPRIDINE**

**Products Affected**
- *dalfampridine*

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<td>MULTIPLE SCLEROSIS (MM): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.</td>
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<td>MM: INITIAL: WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY.</td>
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# DARATUMUMAB

## Products Affected
- DARZALEX

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**DARATUMUMAB-HYALURONIDASE-FIHJ**

**Products Affected**
- DARZALEX FASPRO

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# DAROLUTAMIDE

## Products Affected
- NUBEQA

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# DASATINIB

## Products Affected
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

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<td>PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.</td>
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<td>Indications</td>
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# DECITABINE/CEDAZURIDINE

## Products Affected
- INQOVI

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# DEFERASIROX

**Products Affected**
- *deferasirox*

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<tr>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<td>Other Criteria</td>
<td>CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER. INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO A GENERIC EQUIVALENT OF EITHER EXJADE TABLET FOR ORAL SUSPENSION OR A FORMULARY VERSION OF DEFERASIROX TABLET.</td>
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<td>Off Label Uses</td>
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## DEFERIPRONE

### Products Affected
- **deferiprone**
- FERRIPROX 1,000 MG TAB (2X/DAY)
- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 1,000 MG

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<tr>
<td>Other Criteria</td>
<td>INITIAL CRITERIA: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: (1) TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE, AND (2) ONE OF THE FOLLOWING CRITERIA: A) PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS OR HAS A CONTRAINDICATION TO THESE THERAPIES, OR B) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: I) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), OR II) EVIDENCE OF CARDIAC IRON ACCUMULATION (I.E., CARDIAC T2 STAR MRI LESS THAN 10 MILLISECONDS, IRON INDUCED CARDIOMYOPATHY, FALL IN LEFT VENTRICULAR EJECTION FRACTION, ARRHYTHMIA INDICATING INADEQUATE CHELATION). TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).</td>
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### DEFEROXAMINE

**Products Affected**
- deferoxamine

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<td>CHRONIC IRON OVERLOAD: AT LEAST 3 YEARS OF AGE OR OLDER</td>
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<td>INITIAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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### DEFLAZACORT

**Products Affected**
- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

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<td>DUCHENNE MUSCULAR DYSTROPHY (DMD): DIAGNOSIS CONFIRMED BY GENETIC TESTING.</td>
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<td>DMD: INITIAL: TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE), B) STEROID MYOPATHY HAS BEEN RULED OUT, C) DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E., PULMONARY OR CARDIAC FUNCTION).</td>
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### DELAFLOXACIN

**Products Affected**
- BAXDELA ORAL

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<td><strong>ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI):</strong> ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE STANDARD OF CARE AGENT FOR ABSSSI (E.G., SULFAMETHOXAZOLE/TRIMETHOPRIM, LEVOFLOXACIN, CLINDAMYCIN, CEPHALEXIN, OR VANCOMYCIN), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS FOR ABSSSI: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC. <strong>COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP):</strong> ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID).</td>
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DENOSUMAB-XGEVA

Products Affected
- XGEVA

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# DEUTETRABENAZINE

## Products Affected
- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

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<td>HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.</td>
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<td>TARDIVE DYSKINESIA: PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE.</td>
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# DICHLORPHENAMIDE

## Products Affected
- KEVEYSIS

## PA Criteria

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<td>INITIAL: PATIENT DOES NOT HAVE HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN. RENEWAL: IMPROVEMENT IN SYMPTOMS.</td>
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<td>Off Label Uses</td>
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</table>
## DICLOFENAC EPOLAMINE

### Products Affected
- diclofenac epolamine

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<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
</tr>
<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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DICLOFENAC TOPICAL

Products Affected
- *diclofenac sodium topical gel 3%*
- PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP

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<tr>
<td>Coverage Duration</td>
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<tr>
<td>Other Criteria</td>
<td>PENNSAID 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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## DIMETHYL FUMARATE

### Products Affected
- *dimethyl fumarate oral capsule, delayed release (dr/ec) 120 mg, 120 mg (14)-240 mg (46), 240 mg*

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<td>All FDA-approved Indications.</td>
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DINUTUXIMAB

Products Affected
• UNITUXIN

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## DIROXIMEL FUMARATE

### Products Affected
- VUMERITY

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# DOSTARLIMAB-GXLY

## Products Affected
- JEMPERLI

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## DRONABINOL

### Products Affected
- *dronabinol*

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## DRONABINOL ORAL SOLUTION

### Products Affected
- SYNDROS

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## DROXIDOPA

### Products Affected
- *droxidopa*

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<tr>
<td><strong>Required Medical Information</strong></td>
<td>BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.</td>
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<td>INITIAL: 3 MONTHS RENEWAL: 12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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## DUPILUMAB

### Products Affected
- DUPIXENT PEN
- DUPIXENT SYRINGE

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<tr>
<td><strong>Required Medical Information</strong></td>
<td>INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.</td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>ATOPIC DERMATITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: ATOPIC DERMATITIS, CRSWNP: 6 MOS, ASTHMA: 4 MOS. RENEWAL: 12 MOS (ALL INDICATIONS).</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 3) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS, OR TOPICAL PDE4 INHIBITORS. ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS), 3) NOT CONCURRENTLY RECEIVING XOLAIR OR OTHER ANTI-IL5 BIOLOGICS, AND 4) FOR SEVERE EOSINOPHILIC ASTHMA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: FASENRA OR NUCALA. THE STEP DOES NOT APPLY IF THE REQUEST IS FOR MULTIPLE INDICATIONS AND THE STEP AGENT IS NOT FDA APPROVED FOR ALL INDICATIONS REQUESTED. CRSWNP: 1) EVIDENCE OF NASAL POLYPs BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, AND 3) A 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. RENEWAL: ATOPIC DERMATITIS, CRSWNP: IMPROVEMENT WHILE ON THERAPY. ASTHMA: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.</td>
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<td>PA Criteria</td>
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**DURVALUMAB**

**Products Affected**
- IMFINZI

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# DUVELISIB

## Products Affected
- COPIKTRA

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EDARAVONE

Products Affected
• RADICAVA

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ELAGOLIX SODIUM

Products Affected
• ORILISSA ORAL TABLET 150 MG, 200 MG

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<td>18 YEARS OF AGE AND OLDER</td>
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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION. RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.</td>
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<td>Indications</td>
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ELAPEGADEMASE-LVLR

Products Affected
• REVC OVI

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<td>Prescriber Restrictions</td>
<td>INITIAL: ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>INITIAL: ADA-SCID: ADA-SCID AS MANIFESTED BY ONE OF THE FOLLOWING: 1) CONFIRMATORY GENETIC TEST OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA). PATIENT ALSO MEETS ONE OF THE FOLLOWING: 1) HAS FAILED OR IS NOT A CANDIDATE FOR HEMATOPOIETIC CELL TRANSPLANTATION (HCT) OR 2) REVC OVI WILL BE USED AS BRIDGING THERAPY PRIOR TO PLANNED HCT OR GENE THERAPY. RENEWAL: ADA-SCID: IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE AND THE PATIENT HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY.</td>
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# ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

## Products Affected

- TRIKAFTA

## Exclusion Criteria

| Required Medical Information | CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. |

## Age Restrictions

| Prescriber Restrictions | PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT. |

## Coverage Duration

| Coverage Duration | INITIAL: 6 MONTHS. RENEWAL: LIFETIME. |

## Other Criteria

| Other Criteria | RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |

## Indications

| Indications | All FDA-approved Indications. |

## Off Label Uses

| Off Label Uses |  |

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120
ELIGLUSTAT TARTRATE

Products Affected
• CERDELGA

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# ELOSULFASE ALFA

## Products Affected
- VIMIZIM

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# ELOTUZUMAB

**Products Affected**
- EMPLICITI

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<td>Off Label Uses</td>
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</table>
## ELTROMBOPAG

### Products Affected
- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

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<th>Criteria Details</th>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>ITP: INITIAL: 2 MO. RENEW: 12 MO. HCV: 12 MO. SEVERE APLASTIC ANEMIA: 12 MO.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PATIENT IS UNABLE TO TAKE TABLET FORMULATION. ITP: RENEWAL: PATIENT HAS SHOWN A CLINICAL RESPONSE.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td><strong>Off Label Uses</strong></td>
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</table>

124
EMAPALUMAB-LZSG

Products Affected
• GAMIFANT

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<tr>
<td>Required Medical Information</td>
<td>INITIAL: HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS (HLH): PATIENT HAS UNDERGONE A GENETIC TEST IDENTIFYING HLH-ASSOCIATED GENE MUTATION (E.G., PRF1, UNC13D) OR PATIENT HAS AT LEAST FIVE OF THE FOLLOWING EIGHT DIAGNOSTIC CRITERIA FOR HLH: 1) FEVER, 2) SPLENOMEGALY, 3) CYTOPENIAS (AFFECTING AT LEAST 2 OF 3 CELL LINEAGES), 4) HYPERTRIGLYCERIDEMIA OR HYPOFIBRINOGENEMIA, 5) HEMOPHAGOCYTOSIS IN BONE MARROW OR SPLEEN OR LYMPH NODES AND NO EVIDENCE OF MALIGNANCY, 6) LOW OR ABSENT NATURAL KILLER-CELL ACTIVITY, 7) FERRITIN LEVEL OF 500 MCG/L OR GREATER, 8) SOLUBLE CD25 LEVEL OF 2,400 U/ML OR GREATER.</td>
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<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>HLH: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN IMMUNOLOGIST, HEMATOLOGIST, OR ONCOLOGIST.</td>
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<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 8 WEEKS.</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: HLH: 1) CONCURRENT THERAPY WITH DEXAMETHASONE AND 2) PATIENT EITHER HAS REFRACTORY, RECURRENT, OR PROGRESSIVE DISEASE, OR HAD A TRIAL OF OR INTOLERANCE TO CONVENTIONAL HLH THERAPY (I.E., CHEMOTHERAPY, STEROIDS, IMMUNOTHERAPY). RENEWAL: HLH: 1) PATIENT HAS NOT RECEIVED SUCCESSFUL HEMATOPOIETIC STEM CELL TRANSPLANTATION AND 2) PATIENT HAS DEMONSTRATED IMPROVED IMMUNE SYSTEM RESPONSE FROM BASELINE (E.G., RESOLUTION OF FEVER, DECREASED SPLENOMEGALY, IMPROVEMENT IN CNS SYMPTOMS, IMPROVED CBC, INCREASED FIBRINOGEN LEVELS, REDUCED D-DIMER, REDUCED FERRITIN, REDUCED SOLUBLE CD25 LEVELS.)</td>
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<td>Indications</td>
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<td>Off Label Uses</td>
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ENASIDENIB

Products Affected

- IDHIFA

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ENCORAFENIB

Products Affected
• BRAFTOVI ORAL CAPSULE 75 MG

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<td>Off Label Uses</td>
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# ENDOTHELIN RECEPTOR ANTAGONISTS

## Products Affected
- *ambrisentan*
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

## PA Criteria

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<th>Criteria Details</th>
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<td><strong>Exclusion Criteria</strong></td>
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<td><strong>Required Medical Information</strong></td>
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<tr>
<td><strong>Documented confirmatory pulmonary arterial hypertension (PAH) diagnosis based on right heart catheterization. Patient has NYHA-WHO functional class II-IV symptoms</strong></td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Prescribed by or given in consultation with a cardiologist or pulmonologist.</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
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<tr>
<td><strong>Initial and renewal: 12 months</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
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<tr>
<td><strong>Initial: Mean pulmonary artery pressure (PAP) of at least 25 mmHg or greater, pulmonary capillary wedge pressure (PCWP) of 15 mmHg or less, pulmonary vascular resistance (PVR) greater than 3 Wood units. Ambrisentan: Patient does not have idiopathic pulmonary fibrosis (IPF). Formulary version of bosentan: Patient does not have elevated liver enzymes (ALT, AST) more than 3 times upper limit of normal (ULN) or increases in bilirubin by 2 or more times ULN. Patient is not concurrently taking cyclosporine A or glyburide. Renewal: Patient show improvement from baseline in the 6-minute walk distance or patient has a stable 6-minute walk distance with a stable/improved WHO functional class.</strong></td>
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</table>

## Indications
All FDA-approved Indications.
<table>
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# ENFORTUMAB

## Products Affected
- PADCEV

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<td>Off Label Uses</td>
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**ENTRECTINIB**

**Products Affected**

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

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ENZALUTAMIDE

Products Affected
• XTANDI ORAL CAPSULE
• XTANDI ORAL TABLET 40 MG, 80 MG

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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: CASTRATION-RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# EPOPROSTENOL IV

## Products Affected
- *epoprostenol (glycine)*

## PA Criteria

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<td>DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.</td>
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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<td><strong>Coverage Duration</strong></td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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## Indications
- All FDA-approved Indications.

## Off Label Uses
## ERDAFITINIB

### Products Affected
- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

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## ERENUMAB-AOOE

### Products Affected
- AIMOVIG AUTOINJECTOR

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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>MIGRAINE PREVENTION: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, RENEWAL: EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# ERLOTINIB

**Products Affected**

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

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<td>All FDA-approved Indications.</td>
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ERYTHROPOIESIS STIMULATING AGENTS - RETACRIT

**Products Affected**

- **RETACRIT INJECTION SOLUTION**
  - 10,000 UNIT/ML, 2,000 UNIT/ML,
  - 20,000 UNIT/2 ML, 20,000 UNIT/ML,
  - 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

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<td><strong>Required Medical Information</strong></td>
<td>INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE THERAPY, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS. SURGERY:1 MONTH.</td>
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<td>Other Criteria</td>
<td>RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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# ESKETAMINE

**Products Affected**

- SPRAVATO

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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.</td>
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<td>INITIAL: 3 MONTHS, RENEWAL: 12 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: TRD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) NO ACTIVE SUBSTANCE ABUSE, AND 3) ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION. MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.</td>
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<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<td><strong>Off Label Uses</strong></td>
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**ETANERCEPT**

**Products Affected**
- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

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<td><strong>Required Medical Information</strong></td>
<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.</td>
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<td><strong>Age Restrictions</strong></td>
<td>RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS (PSA): 18 YEARS OR OLDER.</td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.</td>
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<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: RA, PJIA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<th>Indications</th>
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## ETEPLIRSEN

### Products Affected
- EXONDYS-51

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>DMD: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>DMD: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>DMD: INITIAL: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS, RENEWAL: MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</tbody>
</table>
# EVEROLIMUS

## Products Affected
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg
- everolimus (antineoplastic) oral tablet for suspension

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<td>ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.</td>
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<td>Indications</td>
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## FAM-TRASTUZUMAB

### Products Affected
- ENHERTU

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# FEDRATINIB

**Products Affected**
- INREBIC

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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<td>Other Criteria</td>
<td>INITIAL: MYELOFIBROSIS: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF JAKAFI (RUXOLITINIB). RENEWAL: MYELOFIBROSIS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<td>Indications</td>
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# FENFLURAMINE

## Products Affected
- FINTEPLA

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<td>Other Criteria</td>
<td>RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)</td>
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# FENTANYL NASAL SPRAY

## Products Affected
- LAZANDA

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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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</table>
FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

Products Affected
- fentanyl citrate buccal lozenge on a handle

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<td>CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID</td>
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<td>PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-</td>
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<td>RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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## FILGRASTIM

### Products Affected
- GRANIX
- NIVESTYM
- ZARXIO

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<td>Coverage Duration</td>
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<tr>
<td>Other Criteria</td>
<td>NIVESTYM IS THE PREFERRED FILGRASTIM PRODUCT. REQUESTS FOR NIVESTYM DOES NOT REQUIRE A STEP. OTHER FORMULARY VERSIONS OF FILGRASTIM PRODUCTS WILL REQUIRE A TRIAL OF OR CONTRAINDICATION TO NIVESTYM, WHERE INDICATIONS ALIGN.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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FINGOLIMOD

Products Affected
• GILENYA

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# FOSTAMATINIB

## Products Affected
- TAVALISSE

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<td>RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.</td>
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# FREMANEZUMAB-VFRM

## Products Affected
- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<td>MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT EMGALITY. RENEWAL: EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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</table>
**GALCANEZUMAB-GNLM**

**Products Affected**
- EMGALITY PEN
- EMGALITY SYRINGE
  SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X

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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: MIGRAINES: 6 MOS. CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL INDICATIONS): 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. CLUSTER HEADACHE: NO STEP. RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY. RENEWAL FOR EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.</td>
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GEFITINIB

Products Affected
• IRESSA

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<td>Off Label Uses</td>
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**GEMTUZUMAB OZOGAMICIN**

**Products Affected**
- MYLOTARG

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# GILTERITINIB

**Products Affected**

- XOSPATA

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## GIVOSIRAN

### Products Affected

- GIVLAARI

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<td>ACUTE HEPATIC PORPHYRIA (AHP): INITIAL: GENETIC CONFIRMATION OF MUTATION OR ELEVATED URINARY OR PLASMA PBG (PORPHOBILINOGEN) OR ALA (AMINOLEVULINIC ACID).</td>
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<td>Prescriber Restrictions</td>
<td>ACUTE HEPATIC PORPHYRIA (AHP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GENETICIST, HEPATOLOGIST, HEMATOLOGIST, GASTROENTEROLOGIST, NEUROLOGIST, DERMATOLOGIST, OR A HEALTHCARE PROVIDER EXPERIENCED IN MANAGING AHP.</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS</td>
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<td>AHP: INITIAL: HAS EXPERIENCED TWO OR MORE ACUTE HEPATIC PORPHYRIA (AHP) ATTACKS IN THE PAST 12 MONTHS, RENEWAL: 1) HAS ACHIEVED OR MAINTAINED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED A LIVER TRANSPLANT.</td>
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### GLASDEGIB

**Products Affected**
- DAURISMO ORAL TABLET 100 MG, 25 MG

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GLATIRAMER ACETATE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml
- glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml

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**GLECAPREVIR/PIBRENTASVIR**

**Products Affected**
- MAVYRET ORAL TABLET

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<td>MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)</td>
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<td>HCV RNA LEVEL WITHIN PAST 6 MONTHS</td>
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<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.</td>
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<tr>
<td>Coverage Duration</td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.</td>
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<tr>
<td>Other Criteria</td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.</td>
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<td>Off Label Uses</td>
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</table>
GLYCEROL PHENYL BUTYRATE

## Products Affected
- RAVICTI

### PA Criteria | Criteria Details
--- | ---
**Exclusion Criteria** |  
**Required Medical Information** | INITIAL: UREA CYCLE DISORDER (UCD): DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- 12 MONTHS

### Other Criteria
- INITIAL: UREA CYCLE DISORDER (UCD): TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYL BUTYRATE (BUPHENYL). RENEWAL: UCD: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.

### Indications
- All FDA-approved Indications.

### Off Label Uses
## GUSELKUMAB

### Products Affected
- TREMFYA

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<td><strong>Required Medical Information</strong></td>
<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.</td>
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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.</td>
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<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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</table>
# HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

## Products Affected
- morphine concentrate oral solution
- oxycodone oral concentrate

## PA Criteria

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## Coverage Duration

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<td>OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.</td>
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## Other Criteria

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<td>1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.</td>
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## Indications

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## Off Label Uses

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### HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - CLEMASTINE

**Products Affected**
- clemastine oral tablet 2.68 mg

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<td>PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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**HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE**

**Products Affected**
- promethazine injection solution
- promethazine oral
- promethazine rectal
- promethegan

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<td>PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE OR PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.</td>
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**Indications**
All FDA-approved Indications.
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</table>
# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - SCOPOLAMINE

## Products Affected
- *scopolamine base*

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# HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

## Products Affected

- ascomp with codeine
- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen oral tablet 50-325 mg
- butalbital-acetaminophen-caff oral capsule 50-325-40 mg
- butalbital-aspirin-caffeine
- codeine-butalbital-asa-caff
- tencon
- zebutal

## PA Criteria

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<td>PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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## HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

### Products Affected
- *dipyridamole oral*

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<td>PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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# HIGH RISK DRUGS IN THE ELDERLY - DISOPYRAMIDE

## Products Affected

- *disopyramide phosphate oral capsule*

## PA Criteria

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<td>PREScriber acknowledgement/awareness that the drug is considered high risk for patients 65 years and older. Hospice patients will be approved without requiring additional criteria.</td>
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## HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

### Products Affected

- amabelz
- dotti
- DUAVEE
- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet oral tablet 0.5-0.1 mg
- fyavolv
- jinteli
- lylana
- mimvey
- norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

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<td>VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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## HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

### Products Affected
- glyburide
- glyburide micronized
- glyburide-metformin

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<td>TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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# HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

## Products Affected

- ketorolac injection cartridge 15 mg/ml, 30 mg/ml
- ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)
- ketorolac injection syringe 15 mg/ml, 30 mg/ml
- ketorolac intramuscular
- ketorolac oral

## PA Criteria

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</table>
# HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

**Products Affected**
- chlorzoxazone oral tablet 250 mg, 500 mg
- cyclobenzaprine oral tablet 10 mg, 5 mg
- methocarbamol oral

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# HIGH RISK DRUGS IN THE ELDERLY
## ANTICHOLINERGICS - CYPROHEPTADINE_CARBINOXAMINE

**Products Affected**
- carbinoxamine maleate oral liquid
- carbinoxamine maleate oral tablet 4 mg
- cyproheptadine

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# HIGH RISK DRUGS IN THE ELDERLY-
## ANTICHOLINERGICS- DIPHENHYDRAMINE ELIXIR

### Products Affected
- *diphenhydramine hcl oral elixir*

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<tbody>
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<td><strong>Required Medical Information</strong></td>
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<tr>
<td><strong>Age Restrictions</strong></td>
<td>APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.</td>
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<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>ANTIHISTAMINIC CONDITIONS (PRURITUS OR URTICARIA): TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. INSOMNIA: TRIAL OF SILENOR AND BELSOMRA. MOTION SICKNESS AND ANTIPARKINSONISM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS AND ANAPHYLACTIC REACTIONS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</td>
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**Indications**
- All FDA-approved Indications.

**Off Label Uses**
### HIGH RISK DRUGS IN THE ELDERLY - DIPHENOXYLATE-ATROPINE

**Products Affected**
- *diphenoxylate-atropine*

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## HIGH RISK DRUGS IN THE ELDERLY - INDOMETHACIN

### Products Affected
- indomethacin oral capsule 25 mg, 50 mg
- indomethacin oral capsule, extended release

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# HIGH RISK DRUGS IN THE ELDERLY - MEGESTROL

## Products Affected
- megestrol oral suspension 400 mg/10 ml (40 mg/ml)
- megestrol oral tablet

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**HIGH RISK DRUGS IN THE ELDERLY - PAROXETINE**

**Products Affected**
- paroxetine hcl
- PAXIL ORAL SUSPENSION

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## HIGH RISK MEDICATIONS IN THE ELDERLY - PHENOBARBITAL

**Products Affected**
- *phenobarbital*

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## HYDROXYUREA

### Products Affected

- SIKLOS

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# IBRUTINIB

**Products Affected**
- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET

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## IBUPROFEN-FAMOTIDINE

### Products Affected
- ibuprofen-famotidine

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# ICATIBANT

## Products Affected
- *icatibant*
- *sajazir*

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# IDELALISIB

**Products Affected**  
- ZYDELIK

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IMATINIB MESYLATE

Products Affected

- imatinib oral tablet 100 mg, 400 mg

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INFIGRATINIB

Products Affected
• TRUSELTIQ

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## INFLIXIMAB

### Products Affected
- INFLIXIMAB
- REMICADE

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**Indications**

All FDA-approved Indications.

**Off Label Uses**
INFLIXIMAB-ABDA

Products Affected

• RENFLEXIS

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### INFLIXIMAB-AXXQ

**Products Affected**
- AVSOLA

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<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ, TREMFYA. PSO: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. AS: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CD: 1) TRIAL OF OR CONTRAINDICATION TO THE FOLLOWING PREFERRED AGENTS HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER, OR 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. UC: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, XELJANZ FOR PATIENTS 18 YEARS OF AGE AND OLDER. RENEWAL: RA, AS, PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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### INFLIXIMAB-DYYB

**Products Affected**
- INFLECTRA

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<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.</td>
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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
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<td><strong>Coverage Duration</strong></td>
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## INOTUZUMAB OZOGAMICIN

### Products Affected
- BESPONSA

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# INTERFERON ALFA-2B

## Products Affected
- INTRON A INJECTION

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<td>HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).</td>
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<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA AND 24 MONTHS FOR HEPATITIS C. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.</td>
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# INTERFERON GAMMA-1B

## Products Affected
- ACTIMMUNE

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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.</td>
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<td>RENEWAL: THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE AND HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.</td>
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### INTERFERONS FOR MULTIPLE SCLEROSIS-
**AVONEX, BETASERON, PLEGRIDY**

**Products Affected**
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY SUBCUTANEOUS PEN
- INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

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# IPILIMUMAB

## Products Affected
- YERVOY

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<td><strong>Coverage Duration</strong></td>
<td>INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO</td>
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<td><strong>Other Criteria</strong></td>
<td>RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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ISATUXIMAB-IRFC

Products Affected
• SARCLISA

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# ITRACONAZOLE SOLUTION

## Products Affected

- *itraconazole oral solution*

## PA Criteria

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<td>ESOPHAGEAL CANDIDIASIS AND OROPHARYNGEAL CANDIDIASIS: TRIAL OF OR CONTRAINICATION TO FLUCONAZOLE.</td>
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<td>HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.</td>
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<td>CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS</td>
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<td>Prescriber Restrictions</td>
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<td>RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.</td>
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## IVOSIDENIB

### Products Affected
- TIBSOVO

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**IXAZOMIB**

Products Affected

- NINLARO

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# IXEKIZUMAB

## Products Affected
- TALTZ AUTOINJECTOR
- TALTZ SYRINGE
- TALTZ SYRINGE (2 PACK)
- TALTZ SYRINGE (3 PACK)

## Exclusion Criteria

### Required Medical Information

INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).

## Age Restrictions

### Prescriber Restrictions

PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

## Coverage Duration

INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
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LANADELUMAB

Products Affected
• TAKHZYRO

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<td>INITIAL: HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.</td>
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<td>HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.</td>
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<td>HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE, RENEWAL: IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY).</td>
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## LANREOTIDE

**Products Affected**
- **SOMATULINE DEPOT**
  SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML

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# LAPATINIB

## Products Affected
- lapatinib

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## LAROTRECTINIB

### Products Affected
- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

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# LEDIPASVIR-SOFOSBUVIR

## Products Affected
- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

## PA Criteria | Criteria Details
---|---
**Exclusion Criteria**

**Required Medical Information** | HCV RNA LEVEL WITHIN PAST 6 MONTHS.

**Age Restrictions**

**Prescriber Restrictions** | GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

**Coverage Duration** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

**Other Criteria** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/ RITONAVIR. REQUESTS FOR FORMULARY VERSION OF LEDIPASVIR/SOFOSBUVIR: TRIAL OF OR CONTRAINDICATION TO BRAND HARVONI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.

**Indications** | All FDA-approved Indications.

**Off Label Uses** |
LENALIDOMIDE

Products Affected
• REVLIMID

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<td>Coverage Duration</td>
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# LENVATINIB

## Products Affected
- LENVIMA

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<td>Off Label Uses</td>
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## LETERMOVIR

### Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

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<td>Coverage Duration</td>
<td>4 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANTATION AND PATIENT IS NOT RECEIVING THE MEDICATION BEYOND 100 DAYS POST TRANSPLANTATION.</td>
</tr>
<tr>
<td>Indications</td>
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</tr>
<tr>
<td>Off Label Uses</td>
<td></td>
</tr>
</tbody>
</table>
# LEVODOPA

## Products Affected
- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

## PA Criteria | Criteria Details
--- | ---
### Exclusion Criteria
### Required Medical Information
### Age Restrictions
### Prescriber Restrictions
- PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
### Coverage Duration
- INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
### Other Criteria
  - PD: INITIAL: 1) PATIENT IS NOT CURRENTLY TAKING MORE THAN 1600MG OF LEVODOPA PER DAY, AND 2) PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: PATIENT HAD IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF INBRIJA.
### Indications
- All FDA-approved Indications.
### Off Label Uses
# L-GLUTAMINE

## Products Affected

- ENDARI

## Criteria Details

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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>SICKLE CELL DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 12 MONTHS. RENEWAL: LIFETIME.</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: PATIENTS 18 YEARS OR OLDER: ONE OF THE FOLLOWING: 1) AT LEAST 2 SICKLE CELL CRISSES IN THE PAST YEAR, OR 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. PATIENTS 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.</td>
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<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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</table>
LIDOCAINE

Products Affected
- lidocaine hcl mucous membrane solution 4% (40 mg/ml)
- lidocaine topical adhesive patch, medicated 5%
- lidocaine topical ointment
- ZTLIDO

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<tr>
<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</table>
# LIDOCAINE PRILOCAINE

## Products Affected
- *lidocaine-prilocaine topical cream*

## PA Criteria

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<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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LOMITAPIDE

Products Affected
• JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

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<td>PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.</td>
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### PA Criteria

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<td>1) DIAGNOSIS DETERMINED BY A) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, OR B) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR C) CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. 2) LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. 3) TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. 4) MEETS ONE OF THE FOLLOWING: A) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, B) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, C) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), D) STATIN INTOLERANCE, OR E) TRIAL OF ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</td>
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### Indications

All FDA-approved Indications.

### Off Label Uses
### LONCASTUXIMAB TESIRINE-LPYL

**Products Affected**
- ZYNLONTA

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<td>Off Label Uses</td>
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**LORLATINIB**

**Products Affected**
- LORBRENA ORAL TABLET 100 MG, 25 MG

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# LUMACAFTOR-IVACAFTOR

## Products Affected
- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

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<tr>
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<td>INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.</td>
</tr>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>CF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.</td>
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<tr>
<td>Coverage Duration</td>
<td>CF: INITIAL: 6 MONTHS, RENEWAL: LIFETIME.</td>
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<tr>
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<td>RENEWAL: CF: PATIENT MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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LUMASIRAN

Products Affected
• OXLUMO

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**LURBINECTEDIN**

**Products Affected**
- ZEPZELCA

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# LUSUTROMBOPAG

**Products Affected**
- MULPLETA

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<tr>
<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON.</td>
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<td>1) PATIENT HAS A PLANNED PROCEDURE 8 TO 14 DAYS AFTER INITIATION OF MULPLETA AND 2) PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., AVATROMBOPAG, ROMIPLOSTIM, ELTROMBOPAG).</td>
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<td>Indications</td>
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MELPHALAN FLUFENAMIDE HCL

Products Affected
- PEPAXTO

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## MEPOLIZUMAB

### Products Affected
- NUCALA

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<td>INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.</td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE.</td>
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<td><strong>Other Criteria</strong></td>
<td>ASTHMA: INITIAL: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS), AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS, RENEWAL: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.</td>
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## METHYLNALTREXONE

### Products Affected
- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

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<td>ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION.</td>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC, NON-CANCER PAIN.</td>
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<tr>
<td>Other Criteria</td>
<td>ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).</td>
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# METHYLNALTREXONE ORAL

## Products Affected
- RELISTOR ORAL

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<td>Coverage Duration</td>
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<td>CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).</td>
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# MIDOSTAURIN

## Products Affected
- **RYDAPT**

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<td>ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS</td>
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# MIFEPRISTONE

## Products Affected

- KORLYM

## PA Criteria

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<th>Criteria Details</th>
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<tbody>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>INITIAL: CUSHINGS SYNDROME (CS): DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>CS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>CD: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS, RENEWAL: 1) PATIENT CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) PATIENT CONTINUES TO HAVE TOLERABILITY TO KORLYM, AND 3) PATIENT CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</table>
# MIGALASTAT

## Products Affected
- GALAFOLD

## PA Criteria

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<tr>
<td>Required Medical Information</td>
<td>INITIAL: FABRY DISEASE: PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>FABRY DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: 6 MOS. RENEWAL: 12 MOS.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>FABRY DISEASE: INITIAL: NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME), RENEWAL: PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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MIGLUSTAT

Products Affected
• miglustat

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<td>Coverage Duration</td>
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<td>Indications</td>
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MILTEFOSINE

Products Affected
• IMPAVIDO

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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration 12 MONTHS</td>
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<td>Other Criteria</td>
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<td>Indications All FDA-approved Indications.</td>
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# MOBOCERTINIB

## Products Affected
- EXKIVITY

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<td>Coverage Duration</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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# MOXETUMOMAB PASUDOTOX

**Products Affected**
- LUMOXITI

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<tr>
<td>Coverage Duration</td>
<td>6 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>PATIENT HAS NOT PREVIOUSLY RECEIVED 6 CYCLES OF LUMOXITI</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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</table>
# NAPROXEN- ESOMEPRAZOLE

## Products Affected
- naproxen-esomeprazole oral tablet, ir, delayed rel, biphasic 375-20 mg

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<td>Prescriber Restrictions</td>
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</tr>
<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND PROTON PUMP INHIBITORS: OMEPRAZOLE, LANSOPRAZOLE, OR PANTOPRAZOLE AND A TRIAL OF GENERIC, FEDERAL LEGEND NAPROXEN.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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# NARCOLEPSY AGENTS

## Products Affected

- armodafinil

## PA Criteria

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<tr>
<td>Coverage Duration</td>
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<tr>
<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<tr>
<td>Indications</td>
<td>All Medically-accepted Indications.</td>
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**NATALIZUMAB**

**Products Affected**

- TYSABRI

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<tbody>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: MS: TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF MS. CD: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENTS: HUMIRA AND STELARA. RENEWAL: CD: RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI AND HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHNS DISEASE WHILE ON TYSABRI, OR HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI AND HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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### NAXITAMAB-GQGK

#### Products Affected
- DANYELZA

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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# NECITUMUMAB

**Products Affected**
- PORTRAZZA

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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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NERATINIB MALEATE

Products Affected
• NERLYNX

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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>EARLY-STAGE TUMOR (STAGE I-III) AND THE MEDICATION IS BEING REQUESTED WITHIN 2</td>
</tr>
<tr>
<td></td>
<td>YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS</td>
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<tr>
<td></td>
<td>ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA</td>
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<td>APPROVED LABEL.</td>
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<td>Indications</td>
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<td>Off Label Uses</td>
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**NILOTINIB**

**Products Affected**
- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, F359V/C/I, OR G250E.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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### NINTEDANIB

**Products Affected**
- OFEV

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<th>Criteria Details</th>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF ILD [E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY (CYCLOPHOSPHAMIDE, METHOTREXATE, ACE-INHIBITORS), RECURRENT ASPIRATION (SUCH AS FROM GERD), PULMONARY VASCULAR DISEASE, PULMONARY EDEMA, PNEUMONIA, CHRONIC PULMONARY THROMBOEMBOLISM, ALVEOLAR HEMORRHAGE OR ILD CAUSED BY ANOTHER RHEUMATIC DISEASE, SUCH AS MIXED CONNECTIVE TISSUE DISEASE (MCTD)].</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>INITIAL: IPF: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SSC-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. PF-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.</td>
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<td><strong>Age Restrictions</strong></td>
<td>INITIAL: IPF, SSC-ILD, PF-ILD: 18 YEARS OR OLDER.</td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL: 12 MOS.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: IPF: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET. SSC-ILD: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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# NIRAPARIB

**Products Affected**

- ZEJULA

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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: ZEJULA WILL BE USED AS MONOTHERAPY AND IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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NITISINONE

Products Affected

- nitisinone
- NITYR
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

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<th>Criteria Details</th>
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<tr>
<td>Required Medical Information</td>
<td>INITIAL: HEREDITARY TYROSINEMIA TYPE 1 (HT-1): DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>HT-1: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED FORMULARY NITISINONE TABLETS OR CAPSULES, RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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### NIVOLUMAB

**Products Affected**
- OPDIVO

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<td>Prescriber Restrictions</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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# OBETICHLIC ACID

## Products Affected
- OCALIVA

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<td>PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.</td>
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<tr>
<td>Required Medical Information</td>
<td>INITIAL: DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS (PBC) AS CONFIRMED BY TWO OF THE FOLLOWING: 1) ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), 2) PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, OR 3) HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.</td>
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## Age Restrictions

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<th>PBC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.</th>
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<tbody>
<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
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## Other Criteria

| Other Criteria | PBC: INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID, RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. |

## Indications

- All FDA-approved Indications.
# OBINUTUZUMAB

## Products Affected
- GAZYVA

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OCTREOTIDE - ORAL

Products Affected
• MYCAPSSA

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<td>ACROMEGALY: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.</td>
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<td>Coverage Duration</td>
<td>ACROMEGALY: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS</td>
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<td>Other Criteria</td>
<td>ACROMEGALY: INITIAL: RESPONDED TO AND IS CURRENTLY STABLE ON AN INJECTABLE SOMATOSTATIN ANALOG THERAPY. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS OF ACROMEGALY.</td>
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OFATUMUMAB-SQ

Products Affected
• KESIMPTA PEN

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<td>Coverage Duration</td>
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# OLANZAPINE/SAMIDORPHAN

## Products Affected
- LYBALVI

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>SCHIZOPHRENIA/BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST</td>
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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<td>Other Criteria</td>
<td>SCHIZOPHRENIA/BIPOLAR I: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL/FAILURE OF OR CONTRAINDICATION TO LATUDA AND ONE OF THE FOLLOWING FORMULARY ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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### OLAPARIB

**Products Affected**
- LYNPARZA

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<td><strong>Coverage Duration</strong></td>
<td>12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: 1) MEDICATION WILL BE USED AS MONOTHERAPY, AND 2) PATIENT HAS COMPLETED TWO OR MORE LINES OF PLATINUM-BASED CHEMOTHERAPY. ADVANCED GERMLINE BRCA-MUTATED OVARIAN CANCER AFTER 3 OR MORE LINES OF CHEMOTHERAPY: MEDICATION WILL BE USED AS MONOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.</td>
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<td><strong>Indications</strong></td>
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OMACETAXINE

Products Affected
- SYNRIBO

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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENT'S HEMATOLOGIC RESPONSE, DEFINED AS (1) AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR (2) THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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OMALIZUMAB

Products Affected
- XOLAIR

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<tr>
<td>Required Medical Information</td>
<td>INITIAL: ASTHMA: POSITIVE SKIN PRICK OR RAST TEST TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>INITIAL AND RENEWAL: CHRONIC IDIOPATHIC URTICARIA (CIU): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. INITIAL: NASAL POLyps: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.</td>
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<tr>
<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: CIU: TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. NASAL POLYPS: PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS), 3) XOLAIR WILL BE USED AS ADD-ON MAINTENANCE TREATMENT, AND 4) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGIC. RENEWAL: CIU: DIAGNOSIS OF CIU. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.</td>
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**Indications** | All FDA-approved Indications. |

**Off Label Uses** |
OPICAPONE

Products Affected
• ONGENTYS

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<td>Age Restrictions</td>
<td>18 YEARS OF AGE OR OLDER</td>
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<td>Coverage Duration</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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OSIMERTINIB

Products Affected
- TAGRISSO

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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>METASTATIC NSCLC WITH EGFR T790M MUTATION: PATIENT IS NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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# OXYMETHOLONE

## Products Affected
- ANADROL-50

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<td>CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, Nephrosis or the nephrotic phase of nephritis, hypersensitivity to the drug and severe hepatic dysfunction.</td>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Other Criteria</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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## PALBOCICLIB

### Products Affected
- IBRANCE

### PA Criteria

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<td>THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY</td>
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<td>Age Restrictions</td>
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## PALIVIZUMAB

### Products Affected
- SYNAGIS

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<td>GESTATIONAL AGE</td>
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<td>1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.</td>
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<td>Other Criteria</td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY Syncytial Virus Infections. Initial: Approval will be for at least 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY Syncytial Virus (RSV) SEASON. Renewal: Additional 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.</td>
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<td>Indications</td>
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PANITUMUMAB

Products Affected
- VECTIBIX

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# PANOBINOSTAT

## Products Affected

- FARYDAK

## PA Criteria

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<tr>
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<td>12 MONTHS</td>
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<td>Other Criteria</td>
<td>RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.</td>
</tr>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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## PARATHYROID HORMONE

### Products Affected

- NATPARA

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PASIREOTIDE DIASPARTATE

Products Affected
• SIGNIFOR

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>CUSHINGS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.</td>
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<td>INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.</td>
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<td>RENEWAL: CD: PATIENT CONTINUES TO HAVE IMPROVEMENT OF CD AND MAINTAINS TOLERABILITY TO SIGNIFOR.</td>
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PAZOPANIB

Products Affected
• VOTRIENT

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<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

**Products Affected**
- alyq
- sildenafil (pulm.hypertension) oral tablet
- tadalafil (pulm. hypertension)

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<td><strong>Required Medical Information</strong></td>
<td>DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.</td>
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<td><strong>Age Restrictions</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>PAH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<td><strong>Coverage Duration</strong></td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>PAH: INITIAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<td>PA Criteria</td>
<td>Criteria Details</td>
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<tr>
<td>Off Label Uses</td>
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</table>
### PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

**Products Affected**
- *sildenafil* (pulm.hypertension) intravenous

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<tr>
<td><strong>Required Medical Information</strong></td>
<td>DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PAH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>PAH: INITIAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS, RENEWAL: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.</td>
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<td><strong>Indications</strong></td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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## PEGFILGRASTIM

### Products Affected

- FULPHILA
- NEULASTA
- NYVEPRIA
- UDENYCA
- ZIEXTENZO

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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>NYVEPRIA IS THE PREFERRED PEGFILGRASTIM PRODUCT. REQUESTS FOR NYVEPRIA DOES NOT REQUIRE A STEP. OTHER FORMULARY VERSIONS OF PEGFILGRASTIM PRODUCTS WILL REQUIRE A TRIAL OF OR CONTRAINDICATION TO NYVEPRIA, WHERE INDICATIONS ALIGN.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# PEGVALIASE-PQPZ

## Products Affected
- PALYNZIQ

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<tr>
<td>Required Medical Information</td>
<td>RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<td>Age Restrictions</td>
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<td>Coverage Duration</td>
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## PEGVISOMANT

**Products Affected**
- SOMAVERT

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**PEMBROLIZUMAB**

**Products Affected**
- KEYTRUDA

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**PEMIGATINIB**

Products Affected
- PEMAZYRE

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# PENICILLAMINE

## Products Affected
- penicillamine
- THIOLA EC

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<td>INITIAL AND RENEWAL: FORMULARY VERSION OF PENICILLAMINE: RHEUMATOID ARTHRITIS (RA): HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>INITIAL: WILSONS DISEASE: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, 2) IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. RENEWAL: WILSONS DISEASE, CYSTINURIA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
</tr>
</tbody>
</table>

## Age Restrictions

| Prescriber Restrictions | WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |

282
<table>
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<td>INITIAL: RA, WILSONS DISEASE: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) AND THIOLA/THIOLA EC. RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTI RHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. RENEWAL: RA: EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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**PERTUZUMAB**

**Products Affected**
- PERJETA

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<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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</table>
PERTUZUMAB-TRASTUZUMAB-HY-ZZXF

Products Affected

• PHESGO SUBCUTANEOUS
  SOLUTION 1,200 MG-600MG- 30000 UNIT/15ML, 600 MG-600 MG- 20000 UNIT/10ML

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<td>Off Label Uses</td>
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# PEXIDARTINIB

**Products Affected**

- TURALIO

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<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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# PIMAVANSEIN

## Products Affected
- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

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<td>18 YEARS OR OLDER</td>
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<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).</td>
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<td>Coverage Duration</td>
<td>INITIAL 12 MONTHS. RENEWAL 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</table>
PIRFENIDONE

Products Affected
- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

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<th>Criteria Details</th>
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<tr>
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<td>INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>INITIAL: IPF: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE.</td>
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<td>Age Restrictions</td>
<td>IPF: 18 YEARS OR OLDER.</td>
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<td>Prescriber Restrictions</td>
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<td>IPF: INITIAL AND RENEWAL: 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>RENEWAL: IPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</td>
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<td>All FDA-approved Indications.</td>
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# POLATUZUMAB VEDOTIN

**Products Affected**
- POLIVY

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POMALIDOMIDE

Products Affected
• POMALYST

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## PONATINIB

### Products Affected
- ICLUSIG

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<td>Off Label Uses</td>
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## POSACONAZOLE

### Products Affected
- NOXAFIL ORAL SUSPENSION
- posaconazole oral tablet, delayed release (dr/ec)

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<td><strong>Coverage Duration</strong></td>
<td>OROPHARYNGEAL CANDIDIASIS (OPC): 3 MONTHS. PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.</td>
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<td><strong>Other Criteria</strong></td>
<td>POSACONAZOLE SUSPENSION ONLY: 1) OPC: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE OR ITRACONAZOLE. 2) PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. POSACONZOLE TABLETS ONLY: TREATMENT OF INVASIVE ASPERGILLOSIS: NO EXTRA CRITERIA REQUIRED. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.</td>
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<tr>
<td><strong>Indications</strong></td>
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# PRALSETINIB

**Products Affected**
- GAVRETO

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## PRAMLINTIDE

### Products Affected
- SYMLINPEN 120
- SYMLINPEN 60

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<td>TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL</td>
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PYRIMETHAMINE

Products Affected

- *pyrimethamine*

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<td>TOXOPLASMOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.</td>
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<td>TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS.</td>
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<td>RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.</td>
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## QUININE SULFATE

### Products Affected

- quinine sulfate

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## RAMUCIRUMAB

### Products Affected
- CYRAMZA

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REGORAFENIB

Products Affected
• STIVARGA

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# RELUGOLIX

## Products Affected
- ORGOVYX

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RESLIZUMAB

Products Affected
• CINQAIR

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<td>INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.</td>
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<td>ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.</td>
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<td>ASTHMA: INITIAL: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS), AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS, RENEWAL: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.</td>
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# RIBOCICLIB

## Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY (200 MG X 1)-2.5 MG, 400 MG/DAY (200 MG X 2)-2.5 MG, 600 MG/DAY (200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

## PA Criteria

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<td>THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY</td>
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<td>REQUIRES A TRIAL OF OR CONTRAINDICATION TO VERZENIO OR IBRANCE WHERE INDICATIONS ALIGN.</td>
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## Rifaximin

### Products Affected

- Xifaxan Oral Tablet 200 mg, 550 mg

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<td>TRAVELERS DIARRHEA/HE: 12 MOS. IBS-D: 12 WKS.</td>
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<td>RIFAXIMIN 550 MG TABLETS: HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.</td>
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**RIOCIGUAT**

**Products Affected**
- ADEMPAS

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<td>INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF LESS THAN OR EQUAL TO 15 MMHG, AND C) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.</td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<td><strong>Coverage Duration</strong></td>
<td>INITIAL AND RENEWAL: 12 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: PAH: NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS, OR ANY PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.</td>
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## RIPRETINIB

**Products Affected**
- QINLOCK

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# RISANKIZUMAB-RZAA

## Products Affected
- SKYRIZI

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<td>INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.</td>
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<td>PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.</td>
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<td>PSO: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE, RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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# RISDIPLAM

## Products Affected
- EVRYSDI

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<td>SMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROMUSCULAR SPECIALIST OR SPINAL MUSCULAR ATROPHY (SMA) SPECIALIST AT A SMA SPECIALTY CENTER.</td>
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<td>SPINAL MUSCULAR ATROPHY (SMA): INITIAL: DOCUMENTATION OF GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: DOCUMENTATION OF UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING. FOR SYMPTOMATIC PATIENTS: 1) ONSET OF SMA SYMPTOMS OCCURRED BEFORE 20 YEARS OF AGE, 2) DOCUMENTATION OF BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, 3) IF PREVIOUSLY RECEIVED GENE THERAPY, THE PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR OTHER MUSCLE FUNCTION.</td>
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# RITUXIMAB

**Products Affected**
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<td>RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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# RITUXIMAB AND HYALURONIDASE HUMAN-SQ

## Products Affected
- RITUXAN HYCELA

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<td>PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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## RITUXIMAB-ABBS

**Products Affected**
- TRUXIMA

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**RITUXIMAB-ARRX**

**Products Affected**
- RIABNI

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<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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RITUXIMAB-PVVR

Products Affected
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<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<tr>
<td>Off Label Uses</td>
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</table>
# ROMIPLOSTIM

## Products Affected

- NPLATE

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<td><strong>Required Medical Information</strong></td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>ITP: INITIAL: 4 MO, RENEWAL: 12 MO. HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME: 12 MO.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: ITP: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: ITP: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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### ROMOSOZUMAB

**Products Affected**
- EVENITY

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<tr>
<td>Required Medical Information</td>
<td>ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.</td>
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RUCAPARIB

Products Affected
• RUBRACA

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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CAstrate LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.</td>
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# RUXOLITINIB

**Products Affected**
- JAKAFI

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<td><strong>Required Medical Information</strong></td>
<td>MYELOFIBROSIS RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY. ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD): NO RENEWAL CRITERIA.</td>
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**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

**Indications**
- All FDA-approved Indications.

**Off Label Uses**
# SACITUZUMAB

**Products Affected**
- TRODELVY

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SAFINAMIDE MESYLATE

Products Affected
- XADAGO

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**SARILUMAB**

Products Affected

• KEVZARA

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<td>RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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**SATRALIZUMAB-MWGE**

**Products Affected**
- ENSPRYNG

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>NMOSD: PRESCRIBED BY AN OPHTHALMOLOGIST OR PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.</td>
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<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>NMOSD: INITIAL: A) MEETS ONE OF THE FOLLOWING CORE CLINICAL CHARACTERISTIC: OPTIC NEURITIS, ACUTE MYELITIS, AREA POSTREMA SYNDROME, ACUTE BRAINSTEM SYNDROME, SYMPTOMATIC NARCOLEPSY OR ACUTE DIENCEPHALIC CLINICAL SYNDROME WITH NMOSD-TYPICAL DIENCEPHALIC MRI LESIONS, OR SYMPTOMATIC CEREBRAL SYNDROME WITH NMOSD-TYPICAL BRAIN LESIONS, B) PATIENT WILL NOT USE RITUXIMAB, INEBILIZUMAB, OR ECULIZUMAB CONCURRENTLY. NMOSD: RENEWAL: REDUCTION IN RELAPSE FREQUENCY FROM BASELINE.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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SEBELIPASE ALFA

Products Affected
- KANUMA

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<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS</td>
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<td>Off Label Uses</td>
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</table>
## SECUKINUMAB

### Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML

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<th>PA Criteria</th>
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<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
</tr>
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### Notes

- COSENTYX and COSENTYX PEN are available in combinations of 2 syringes and 2 pens, respectively.
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML is a standalone product for subcutaneous administration.

- **PA Criteria** refer to the necessary medical and clinical criteria for approval. These may include the severity of the condition, treatment history, and other relevant factors.

- **Exclusion Criteria** outline conditions for which the drug may not be prescribed.

- **Required Medical Information** is detailed for each condition, specifying specific criteria that must be met.

- **Age Restrictions** may vary based on the condition and the age of the patient.

- **Prescriber Restrictions** stipulate who may prescribe the medication, ensuring it is provided by a qualified medical professional.

- **Coverage Duration** indicates the time period for which the drug is covered under a plan or program.
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<th>Criteria Details</th>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG). AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). RENEWAL: PSO, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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SELEXIPAG

Products Affected
• UPTRAVI INTRAVENOUS
• UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
• UPTRAVI ORAL TABLETS, DOSE PACK

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<tr>
<td>Required Medical Information</td>
<td>INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF LESS THAN OR EQUAL TO 15 MMHG, AND C) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>PAH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>INITIAL: PAH: WHO FC II-III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAL RECEPTOR ANTAGONIST (E.G., AMBRISENTAN, BOSENTAN, MACITENTAN), 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR (E.G., SILDENAFIL, TADALAFIL), OR 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR (E.G., RIOCIGUAT). WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: NO STEP. RENEWAL: PAH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<td><strong>Off Label Uses</strong></td>
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**SELINEXOR**

**Products Affected**
- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (20 MG X 2), 40 MG/WEEK (40 MG X 1), 40 MG TWICE WEEK (40 MG X 2), 40 MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60 MG/WEEK (60 MG X 1), 60 MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80 MG/WEEK (40 MG X 2), 80 MG TWICE WEEK (160 MG/WEEK)

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SELPERCATINIB

Products Affected
• RETEVMO ORAL CAPSULE 40 MG, 80 MG

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SELUMETINIB

Products Affected
• KOSELUGO ORAL CAPSULE 10 MG, 25 MG

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# SILTUXIMAB

**Products Affected**

- SYLVANT

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## SIPONIMOD

**Products Affected**
- MAYZENT ORAL TABLET 0.25 MG, 2 MG
- MAYZENT STARTER PACK

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<td>Other Criteria</td>
<td>MULTIPLE SCLEROSIS: RENEWAL: 1) DEMONSTRATION OF CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE AND 2) DOES NOT HAVE LYMPHOPENIA.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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# SODIUM OXYBATE

## Products Affected
- XYREM

## PA Criteria

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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH ONE OF THE FOLLOWING SPECIALISTS: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>INITIAL 6 MONTHS. RENEWAL: 12 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>ALL INDICATIONS: INITIAL: THE PATIENT IS NOT CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS. EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: FOR PATIENTS 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, PITOLISANT OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. FOR PATIENTS 7 TO 17 YEARS OF AGE: TRIAL OF OR CONTRAINDICATION TO ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. RENEWAL: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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</tbody>
</table>
## SOFOSBUVIR/VELPATASVIR

### Products Affected
- EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG
- EPCLUSA ORAL TABLET

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<th>Criteria Details</th>
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<tr>
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<tr>
<td><strong>Required Medical Information</strong></td>
<td>HCV RNA LEVEL.</td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RTONAVIR OR TOPOTECAN. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. REQUESTS FOR FORMULARY VERSION OF SOFOSBUVIR/VELPATASVIR: TRIAL OF OR CONTRAINDICATION TO BRAND EPCLUSA.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>PA Criteria</td>
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<tr>
<td>Off Label Uses</td>
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</table>
### SOFOSBUVIR/VELPATASVIR/VOXILAPREVI

**Products Affected**
- VOSEVI

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<th>Criteria Details</th>
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<tr>
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<td>MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).</td>
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<tr>
<td>Required Medical Information</td>
<td>HCV RNA LEVEL WITHIN PAST 6 MONTHS</td>
</tr>
<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.</td>
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<tr>
<td>Coverage Duration</td>
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</tr>
<tr>
<td>Other Criteria</td>
<td>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/ RITONAVIR.</td>
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</table>

**Indications**
- All FDA-approved Indications.

**Off Label Uses**
## SOLRIAMFETOL

### Products Affected
- SUNOSI

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<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Initial: 6 months. Renewal: 12 months.</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. OBSTRUCTIVE SLEEP APNEA (OSA): THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL. Renewal: Sustained improvement of symptoms compared to baseline.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td><strong>Off Label Uses</strong></td>
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# SOMATROPIN - NORDITROPIN

## Products Affected
- NORDITROPIN FLEXPRO

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<td>INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), Turner Syndrome (TS), Noonan Syndrome: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. Prader Willi Syndrome (PWS): CONFIRMED GENETIC DIAGNOSIS.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS.</td>
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<td>Criteria Details</td>
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<tr>
<td>Off Label Uses</td>
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# SOMATROPIN - SEROSTIM

## Products Affected
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

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<td>ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.</td>
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<tr>
<td><strong>Required Medical Information</strong></td>
<td>INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARE, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARE, OR BMI LESS THAN 18.5 KG PER METER SQUARE.</td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>HIV/WASTING: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.</td>
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<td><strong>Coverage Duration</strong></td>
<td>INITIAL AND RENEWAL: 3 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>HIV/WASTING: INITIAL: INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS), RENEWAL: CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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SOMATROPIN - ZORBITIVE

Products Affected
- ZORBITIVE

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<td>Prescriber Restrictions</td>
<td>SHORT BOWEL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
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<td>SHORT BOWEL: 4 WEEKS ONCE.</td>
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SONIDEGIB

Products Affected
• ODOMZO

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<td>BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS</td>
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# SORAFENIB TOSYLATE

## Products Affected
- NEXAVAR

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<td>Coverage Duration</td>
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SOTORASIB

Products Affected
- LUMAKRAS

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<td>Off Label Uses</td>
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# STIRIPENTOL

## Products Affected
- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
<td>DRAVET SYNDROME: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>RENEWAL: DRAVET SYNDROME: CURRENTLY TREATED WITH CLOBAZAM.</td>
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<td>All FDA-approved Indications.</td>
</tr>
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<td>Off Label Uses</td>
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# SUNITINIB MALATE

## Products Affected
- *sunitinib*

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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<td><strong>Other Criteria</strong></td>
<td>GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.</td>
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<td>Off Label Uses</td>
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### TADALAFIL

**Products Affected**
- tadalafil oral tablet 2.5 mg, 5 mg

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<td>ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.</td>
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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>TRIAL OF ONE FORMULARY ALPHA BLOCKER SUCH AS DOXAZOSIN, TERAZOSIN, TAMSULOSIN OR ALFUZOSIN) AND ONE FORMULARY 5-ALPHA-REDUCTASE (SUCH AS FINASTERIDE OR DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</table>
# TAFAMIDIS

## Products Affected
- VYNDAMAX
- VYNDAQEL

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<tr>
<td>Required Medical</td>
<td>RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.</td>
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<tr>
<td>Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL AND RENEWAL: 12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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### TAFASITAMAB-CXIX

**Products Affected**
- MONJUVI

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</tr>
<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# TALAZOPARIB

## Products Affected
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

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</tr>
<tr>
<td>Coverage Duration</td>
<td>12 MONTHS</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY.</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td>Off Label Uses</td>
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</table>
### TALIMOGENE

**Products Affected**
- **IMLYGIC INJECTION SUSPENSION**
  10^6 (1 MILLION) PFU/ML, 10^8 (100 MILLION) PFU/ML

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<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>12 MONTHS</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>1) IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND/OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE, 2) NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY, 3) NO HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS, AND 4) NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.</td>
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<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<tr>
<td><strong>Off Label Uses</strong></td>
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## TASIMELTEON

### Products Affected

- HETLIOZ
- HETLIOZ LQ

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<tr>
<td>Coverage Duration</td>
<td>LIFETIME</td>
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<td>Other Criteria</td>
<td>NON-24 HOUR SLEEP-WAKE DISORDER: PATIENT IS LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS.</td>
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<td>Off Label Uses</td>
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**TAZEMETOSTAT**

**Products Affected**
- TAZVERIK

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### TEDUGLUTIDE

**Products Affected**
- GATTEX 30-VIAL

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<td>Coverage Duration</td>
<td>12 MONTHS</td>
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<tr>
<td>Other Criteria</td>
<td>PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK</td>
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**TELOTRISTAT**

**Products Affected**
- XERMELO

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<td>Off Label Uses</td>
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# TEMOZOLOMIDE

**Products Affected**

- TEMODAR INTRAVENOUS

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<td>Off Label Uses</td>
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# TEPOTINIB

**Products Affected**
- TEPMETKO

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TEPROTUMUMAB-TRBW

Products Affected
• TEPEZZA

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<td>Off Label Uses</td>
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**TERIFLUNOMIDE**

**Products Affected**
- AUBAGIO

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<td>Off Label Uses</td>
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# TESAMORELIN

**Products Affected**

- EGRIFTA
- EGRIFTA SV

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<td><strong>Coverage Duration</strong></td>
<td>3 MONTHS</td>
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<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td><strong>Off Label Uses</strong></td>
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</tbody>
</table>
# TESTOSTERONE

## Products Affected

- Testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)
- Testosterone enanthate
- Testosterone transdermal gel in metered-dose pump 12.5 mg/1.25 gram (1%), 20.25 mg/1.25 gram (1.62%)
- Testosterone transdermal gel in packet 1% (25 mg/2.5 gram), 1% (50 mg/5 gram)
- Testosterone transdermal solution in metered pump"wapp""Xysted"

## PA Criteria

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<tbody>
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<tr>
<td>Required Medical Information</td>
<td>INITIAL: MALE HYPOGONADISM: CONFIRMED BY: 1) AT LEAST TWO MORNING TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS WHILE IN A FASTED STATE, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.</td>
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<tr>
<td>Age Restrictions</td>
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</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>PRIMARY OR SECONDARY HYPOGONADISM: 12 MO. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>MALE HYPOGONADISM: RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# TETRABENAZINE

## Products Affected
- *tetrabenazine*

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<td>Prescriber Restrictions</td>
<td>NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST</td>
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<td>Off Label Uses</td>
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# TEZACAFTOR/IVACAFTOR

## Products Affected
- SYMDEKO

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<tr>
<td><strong>Required Medical Information</strong></td>
<td>CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: LIFETIME</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
</tr>
<tr>
<td><strong>Off Label Uses</strong></td>
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</table>
# THALIDOMIDE

**Products Affected**
- THALOMID

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<tr>
<td>Off Label Uses</td>
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# TILDRAKIZUMAB-ASMN

**Products Affected**
- ILUMYA

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<tr>
<td>Required Medical Information</td>
<td>INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>PSO: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS</td>
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<td>Other Criteria</td>
<td>INITIAL: PSO: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI, TREMFYA. RENEWAL: PSO: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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## TISOTUMAB VEDOTIN-TFTV

**Products Affected**
- TIVDAK

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TIVOZANIB

Products Affected
• FOTIVDA

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## TOCILIZUMAB IV

### Products Affected
- ACTEMRA

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<tr>
<td>Prescriber Restrictions</td>
<td>RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>INITIAL: RA, PJIA, SJIA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA: 12 MONTHS.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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### TOCILIZUMAB SQ

#### Products Affected
- ACTEMRA
- ACTEMRA ACTPEN

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<td>SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF ILD [E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY (CYCLOPHOSPHAMIDE, METHOTREXATE, ACE-INHIBITORS), RECURRENT ASPIRATION (SUCH AS FROM GERD), PULMONARY VASCULAR DISEASE, PULMONARY EDEMA, PNEUMONIA, CHRONIC PULMONARY THROMBOEMBOLISM, ALVEOLAR HEMORRHAGE OR ILD CAUSED BY ANOTHER RHEUMATIC DISEASE, SUCH AS MIXED CONNECTIVE TISSUE DISEASE (MCTD)].</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SSC-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.</td>
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<p>| Coverage Duration             | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.                                                                                                          |</p>
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</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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## TOFACITINIB

### Products Affected

- XELJANZ
- XELJANZ XR

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<td>RHEUMATOID ARTHRITIS (RA), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR Maximally Tolerated dose is required. PSA, PCJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYL PREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: RA, PSA, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>All FDA-approved Indications.</td>
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### Indications

- All FDA-approved Indications.
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<td>Off Label Uses</td>
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**TOLVAPTAN**

**Products Affected**
- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

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<td>RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.</td>
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<td>Age Restrictions</td>
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<td>PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).</td>
</tr>
<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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375
# TOPICAL TRETINOIN

## Products Affected
- ALTRENO
- *tretinoin*

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<td><strong>Exclusion Criteria</strong></td>
<td>COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.</td>
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<td><strong>Required Medical Information</strong></td>
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<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>12 MONTHS</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY GENERIC TOPICAL TRETINOIN PRODUCT.</td>
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<td><strong>Indications</strong></td>
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# TRABECTEDIN

## Products Affected
- YONDELIS

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### TRAMETINIB

**Products Affected**
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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# TRASTUZUMAB

## Products Affected
- HERCEPTIN INTRAVENOUS RECON SOLN 150 MG

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<td><strong>Coverage Duration</strong></td>
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<td><strong>Other Criteria</strong></td>
<td>ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGVIRI, ONTRUZANT, TRAZIMERA. THIS DRUG ALSO Requires payment determination and may be covered under Medicare Part B or D.</td>
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# TRASTUZUMAB HYALURONIDASE

## Products Affected
- HERCEPTIN HYLECTA

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## TRASTUZUMAB-ANNS

**Products Affected**  
- KANJINTI

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# TRASTUZUMAB-DKST

## Products Affected
- OGIVRI

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This drug also requires payment determination and may be covered under Medicare Part B or D.
# TRASTUZUMAB-DTTB

**Products Affected**
- ONTRUZANT

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# TRASTUZUMAB-PKRB

## Products Affected
- HERZUMA

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**TRASTUZUMAB-QYYP**

**Products Affected**
- TRAZIMERA

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<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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## TREPROSTINIL INHALED

### Products Affected
- TYVASO

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<td>INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF LESS THAN OR EQUAL TO 15 MMHG, AND C) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) III-IV SYMPTOMS. PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 30 MMHG, 2) PULMONARY VASCULAR RESISTANCE (PVR) OF AT LEAST 4 WOOD UNITS, AND 3) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF LESS THAN OR EQUAL TO 12 MMHG IF PVR IS 4 WU TO LESS THAN 6.25 WU, OR PCWP OF LESS THAN OR EQUAL TO 15 MMHG IF PVR IS AT LEAST 6.25 WU.</td>
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<td>PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</td>
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<tr>
<td>Other Criteria</td>
<td>INITIAL: PAH: WHO FC III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAL RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR, OR 3) FORMULARY VERSION OF AN ORAL CGMP INHIBITOR, WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF AN IV/SQ PROSTACYCLIN. RENEWAL: PAH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE. PH-ILD: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR A STABLE 6-MINUTE WALK DISTANCE TEST. 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.</td>
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# TREPROSTINIL SODIUM INJECTABLE

## Products Affected
- treprostinil sodium

## PA Criteria

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<td><strong>Age Restrictions</strong></td>
<td>PAH: INITIAL AND RENEWAL: 12 MONTHS.</td>
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<td><strong>Prescriber Restrictions</strong></td>
<td>INITIAL: PAH: CONTINUATION FROM HOSPITAL DISCHARGE FOR WHO FC II-IV: NO STEP. NEW STARTS FOR WHO FC III-IV: NO STEP. NEW STARTS FOR WHO FC II: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR, OR 3) FORMULARY VERSION OF AN ORAL CGMP INHIBITOR. RENEWAL: PAH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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## TRIENTINE

### Products Affected

- clovique
- trientine

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<td>WILSONS DISEASE: INITIAL: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS, RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<td>INITIAL: WILSONS DISEASE: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE (DEPEN).</td>
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TRIFLURIDINE/TIPIRACIL

Products Affected
• LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

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## TUCATINIB

### Products Affected
- TUKYSA ORAL TABLET 150 MG, 50 MG

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<td>Off Label Uses</td>
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# UBROGEPANT

**Products Affected**  
- UBRELVY

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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td>Other Criteria</td>
<td>INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTAN. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT AS DEFINED BY ONE OF THE FOLLOWING: 1) ABILITY TO FUNCTION NORMALLY WITHIN 2 HOURS OF DOSE, 2) HEADACHE PAIN DISAPPEARS WITHIN 2 HOURS OF DOSE, 3) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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UMBRALISIB

Products Affected
• UKONIQ

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## UPADACITINIB

### Products Affected
- RINVOQ

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<td><strong>Prescriber Restrictions</strong></td>
<td>RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.</td>
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<td><strong>Other Criteria</strong></td>
<td>RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED, RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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<td><strong>Indications</strong></td>
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# URIDINE TRIACETATE

**Products Affected**

- XURIDEN

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<td>INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)</td>
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<td>PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES</td>
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## USTEKINUMAB

### Products Affected
- STELARA

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<td><strong>Required Medical Information</strong></td>
<td>INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<td><strong>Other Criteria</strong></td>
<td>INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYL PREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.</td>
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# USTEKINUMAB IV

## Products Affected
- STELARA

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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.</td>
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<td>CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
</tr>
<tr>
<td><strong>Indications</strong></td>
<td>All FDA-approved Indications.</td>
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<td><strong>Off Label Uses</strong></td>
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**VANDETANIB**

**Products Affected**
- CAPRELSA ORAL TABLET 100 MG, 300 MG

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VEMURAFENIB

Products Affected
• ZELBORAF

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<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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VENETOCLAX

Products Affected
• VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
• VENCLEXTA STARTING PACK

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### VESTRONIDASE ALFA VJBK

**Products Affected**
- MEPSEVII

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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>MUCOPOLYSACCHARIDOSIS VII (MPS VII): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN GENETIC OR METABOLIC DISORDERS.</td>
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<tr>
<td>Coverage Duration</td>
<td>INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.</td>
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<tr>
<td>Other Criteria</td>
<td>MPS VII: INITIAL: 1) PATIENT HAS NOT UNDERGONE SUCCESSFUL BONE MARROW OR STEM CELL TREATMENT FOR MPS VII, 2) PATIENT HAS LIMITATION IN MOBILITY, BUT REMAINS SUFFICIENTLY AMBUATLORY, AND 3) DIAGNOSIS OF MPS VII CONFIRMED BY ALL OF THE FOLLOWING CRITERIA: A) URINARY GAG (GLYCOSAMINOGLYCAN) LEVEL OF GREATER THAN THREE TIMES THE UPPER LEVEL OF NORMAL BASED ON THE LABORATORY ASSAY, B) BETAGLUCURONIDASE ENZYME ACTIVITY DEFICIENCY OR GENETIC TESTING, AND C) ONE OF THE FOLLOWING CLINICAL SIGNS OF MPS VII: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTIONS OR PULMONARY DYSFUNCTION, RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY FROM BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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<td>PA Criteria</td>
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<td>All FDA-approved Indications.</td>
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<td>Off Label Uses</td>
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# VIGABATRIN

## Products Affected

- *vigabatrin*
- *vigadrone*

## PA Criteria

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<td>Prescriber Restrictions</td>
<td>REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.</td>
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<td>CPS: PATIENT HAS RESPONDED INADEQUATELY TO AT LEAST 2 ANTIEPILEPTIC AGENTS. CPS AND INFANTILE SPASMS: BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS.</td>
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<td>Indications</td>
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VINCRISTINE SULFATE LIPOSOMAL

Products Affected
- MARQIBO

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<td>THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</td>
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**VISMODEGIB**

**Products Affected**
- ERIVEDGE

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<td>Off Label Uses</td>
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# VORICONAZOLE SUSPENSION

## Products Affected
- voriconazole oral suspension for reconstitution

## PA Criteria

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<td>Prescriber Restrictions</td>
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<td>CANDIDA INFECTIONS: 3 MOS. ALL OTHER INDICATIONS: 6 MOS.</td>
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<td>CANDIDA INFECTIONS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE. ALL INDICATIONS: INABILITY TO SWALLOW TABLETS OR AN INDICATION FOR ESOPHAGEAL CANDIDIASIS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.</td>
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<tr>
<td>Indications</td>
<td>All FDA-approved Indications.</td>
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## ZANUBRUTINIB

### Products Affected

- BRUKINSA

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# ZIV-AFLIBERCEPT

## Products Affected
- ZALTRAP

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<tr>
<td>COMETRIQ</td>
<td>59</td>
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<tr>
<td>COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML</td>
<td>160</td>
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<tr>
<td>COPIKTRA</td>
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<td>COSENTYX (2 SYRINGES)</td>
<td>326</td>
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<td>COSENTYX PEN (2 PENS)</td>
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<td>COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML</td>
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<td>cyclobenzaprine oral tablet 10 mg, 5 mg</td>
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<td>cyproheptadine</td>
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<td>CYRAMZA</td>
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<td>CYSTADROPS</td>
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<td>CYSTARAN</td>
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<td>dalfaximidine</td>
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<td>DANYELZA</td>
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<td>DARZALEX</td>
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<td>DARZALEX FASPRO</td>
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<td>DAURISMO ORAL TABLET 100 MG, 25 MG</td>
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<td>deferoxamine</td>
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<td>DIACOMIT ORAL CAPSULE 250 MG, 500 MG</td>
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<tr>
<td>diclofenac epolamine</td>
<td>102</td>
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<td>diclofenac sodium topical gel 3%</td>
<td>103</td>
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<tr>
<td>dimethyl fumarate oral capsule, delayed release (dfrec) 120 mg, 120 mg (14)-240 mg (46), 240 mg</td>
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<td>diphenhydramine hcl oral elixir</td>
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