Prior Authorization Criteria
Last Updated: September 28, 2023
Effective Date: January 1, 2024

2024 **Prior Authorizations**

(List of Prior Authorizations)

PLEASE READ CAREFULLY: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE PRIOR AUTHORIZATIONS ON DRUGS THAT WE COVER IN THIS PLAN.

Note to existing members: Beneficiaries must use network pharmacies to access their prescription drug benefit. "Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year."

IEHP DualChoice (HMO D-SNP) is a HMO Plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.

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Puede obtener este documento gratis en otros formatos, como letra grande, Braille y/o audio. Llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), 8am a 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

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Quý vị có thể tải miễn phí tài liệu này ở các định dạng khác, chẳng hạn như bản in cỡ lớn, chữ nổi Braille và/hoặc tệp âm thanh. Hãy gọi Ban Dịch Vụ Hội Viên IEHP DualChoice theo số 1-877-273-IEHP (4347), 8 giờ sáng - 8 giờ tối (Múi giờ PST), 7 ngày ngày trong tuần, kể cả các ngày lễ. Người dùng TTY vui lòng gọi số 1-800-718-4347. Miễn phí cước gọi.

ABELCET

Products Affected

- ABELCET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ABILIFY MAINTENA

Products Affected

- ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML, 960 MG/3.2 ML
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral aripiprazole without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist, Orthopedist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADHD

Products Affected

- *dexmethylphenidate oral tablet*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule,er biphasic 50-50*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AIMOVIG

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist, Headache Specialist, Pain Specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: divalproex, valproic acid, or topiramate and failure or clinically significant adverse effects to one of the formulary alternatives: metoprolol, timolol, propranolol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ALOSETRON

Products Affected

- *alosetron*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to the formulary alternative: loperamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMBISOME

Products Affected

- AMBISOME
- *amphotericin b liposome*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMITRIPTYLINE

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg*
- *perphenazine-amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMOXAPINE

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMPHOTERICIN B

Products Affected

- *amphotericin b*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTICONVULSANTS 1

Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG
- EPIDIOLEX
- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTICONVULSANTS 2

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- DIACOMIT
- FINTEPLA
- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Clobazam, Fenfluramine, or Stiripentol: Must be used as adjunctive treatment of seizure. Lacosamide: For partial seizure: Failure or clinically significant adverse effects to two of the following: carbamazepine, divalproex, felbamate, gabapentin, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide. For tonic-clonic seizure: Failure or clinically significant adverse effects to two of the following: lamotrigine, levetiracetam, phenytoin, or topiramate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ANTINEOPLASTIC

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG
- AKEEGA
- ALECENSA
- ALUNBRIG
- AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG
- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG
- BESREMI
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE (ACALABRUTINIB MAL)
- CAPRELSA
- COMETRIQ
- COPIKTRA
- COTELLIC
- DAURISMO ORAL TABLET 100 MG, 25 MG
- ERIVEDGE
- ERLEADA ORAL TABLET 240 MG, 60 MG
- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- *everolimus (antineoplastic) oral tablet*
- *everolimus (antineoplastic) oral tablet for suspension 3 mg, 5 mg*
- EXKIVITY
- FOTIVDA
- GAVRETO
- *gefitinib*
- GILOTRIF
- GLEOSTINE
- IBRANCE
- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG
- IDHIFA
- *imatinib oral tablet 100 mg, 400 mg*
- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG
- INLYTA ORAL TABLET 1 MG, 5 MG
- INQOVI
- INREBIC
- IRESSA
- JAKAFI
- JAYPIRCA ORAL TABLET 100 MG, 50 MG
- KISQALI FEMARA CO-PACK
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)
- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- KRAZATI
- *lapatinib*
- *lenalidomide*
- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)
- LONSURF
- LORBRENA ORAL TABLET 100 MG, 25 MG
- LUMAKRAS ORAL TABLET 120 MG, 320 MG
- LYNPARZA
- LYTGOBI
- MATULANE
- MEKINIST ORAL RECON SOLN
- MEKINIST ORAL TABLET 0.5 MG, 2 MG
- MEKTOVI
- NERLYNX
- NEXAVAR

- NINLARO
- NUBEQA
- ODOMZO
- ONUREG
- ORGOVYX
- ORSERDU ORAL TABLET 345 MG, 86 MG
- PANRETIN
- PEMAZYRE
- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)
- POMALYST
- PURIXAN
- QINLOCK
- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- REVLIMID
- REZLIDHIA
- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- RUBRACA
- RYDAPT
- SCEMBLIX ORAL TABLET 20 MG, 40 MG
- *sorafenib*
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG
- STIVARGA
- *sunitinib malate*
- SUTENT
- SYNRIBO
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1), 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2), 75 MG/DAY (25 MG X 3)
- TUKYSA ORAL TABLET 150 MG, 50 MG
- TURALIO ORAL CAPSULE 125 MG, 200 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION
- VIZIMPRO
- VONJO
- VOTRIENT
- WELIREG
- XALKORI
- XERMELO
- XOSPATA
- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)
- XTANDI
- YONSA
- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

APREPITANT

Products Affected

- *aprepitant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to one of the formulary 5-HT3 antagonist alternatives: ondansetron or granisetron except when the member is on any chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATOVAQUONE

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUBAGIO

Products Affected

- AUBAGIO
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an MAOI. Untreated or inadequately-treated depression, or current suicidality in patients with Huntington disease.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chorea (Huntington's Disease): Failure or clinically significant adverse effects to the formulary alternative: tetrabenazine. Reauthorization only: Documentation of positive response to medication therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUVELITY

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BRONCHITOL

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	New: Documentation that patient has passed the BRONCHITOL Tolerance Test (BTT). Reauthorization only: Documentation of positive response to medication therapy (improvement in lung function as determined by change in FEV1).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CASPOFUNGIN

Products Affected

- *caspofungin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, Dermatologist, or Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR. Crohn's Disease: Failure or clinically significant adverse effects to two of the formulary alternatives: Humira, Stelara, or Skyrizi. Psoriatic arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Stelara, Xeljanz IR/XR, Rinvoq, or Skyrizi. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR. Non-radiographic Axial Spondyloarthritis: Failure or clinically significant adverse effects to the formulary alternative: Cosentyx. Plaque psoriasis: Failure or clinically significant adverse effects to two of the formulary alternatives: Humira, Stelara, Enbrel, or Skyrizi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CLOMIPRAMINE

Products Affected

- *clomipramine*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following: Concomitant use of an MAOI, or Use within 14 days of discontinuing an MAOI, or Concomitant use of linezolid, or Concomitant use of intravenous methylene blue, or Use during the acute recovery period after a myocardial infarction.
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Obsessive-Compulsive Disorder: Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, or sertraline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CONSTIPATION AGENTS

Products Affected

- MOVANTIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: lactulose or polyethylene glycol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Heart failure in adult patients: Documented New York Association (NYHA) class II to IV heart failure with an ejection fraction of less than or equal to 35% and sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute (bpm). Documentation that patient is on maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication or a hypersensitivity to beta blocker. Documented concurrent use with an ACE inhibitor or ARB, unless both are not tolerated or contraindicated. Heart failure in pediatric patients: Documented NYHA/Ross class II to IV heart failure with an ejection fraction of less than or equal to 45% and sinus rhythm with a resting heart rate greater than or equal to 105 bpm in the age subset 6-12 months, greater than or equal to 95 bpm in the age subset 1-3 years, greater than or equal to 75 bpm in the age subset 3-5 years, greater than or equal to 70 bpm in the age subset 5-18 years
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

COSENTYX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Ankylosing spondylitis: For adults, failure or clinically significant adverse effects to both of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: For adults, failure or clinically significant adverse effects to both of the formulary alternatives: Enbrel and Humira. Plaque Psoriasis: For adults, failure or clinically significant adverse effects to one of the formulary alternatives: Humira, Enbrel, or Skyrizi. Non-radiographic Axial Spondyloarthritis: Failure or clinically significant adverse effects to a non-steroidal anti-inflammatory drug (NSAID) or has an intolerance or contraindication to NSAID.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe renal impairment (CrCL 50 mL/min or less).
Required Medical Information	Concurrently on a disease-modifying agent for multiple sclerosis. Documentation of difficulty walking (such as timed 25-foot walk test: Patient must be able to walk 25 feet within 8-45 sec). Reauthorization only: Documentation of positive response to medication therapy.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DALIRESP

Products Affected

- DALIRESP
- *roflumilast*

PA Criteria	Criteria Details
Exclusion Criteria	Liver impairment, moderate to severe (Child-Pugh B or C).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: either Wixela or Fluticasone/Salmeterol, Anoro Ellipta, Serevent, Spiriva or Tudorza.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERASIROX

Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DESIPRAMINE

Products Affected

- *desipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIAZEPAM SOLUTION

Products Affected

- *diazepam intensol*
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Arrhythmia: Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, flecainide, mexiletine, propafenone, quinidine, or sotalol.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DOXEPIN

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	For the average daily dose of doxepin that is greater than 6 mg: Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, duloxetine, escitalopram, or venlafaxine. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DRIZALMA

Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow an intact capsule or failure or clinically significant adverse effects to the formulary alternative: duloxetine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial: eosinophilic asthma: blood eosinophil level greater than or equal to 150 cells/mcl within the past 12 months. Eosinophilic Esophagitis: diagnosis confirmed by esophagogastroduodenoscopy with biopsy.
Age Restrictions	
Prescriber Restrictions	Initial: Atopic Dermatitis, Prurigo Nodularis: 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: prescribed by or in consultation with an Otolaryngologist, Allergist or Immunologist. Eosinophilic Esophagitis: prescribed by or in consultation with a Gastroenterologist, Allergist, or Immunologist.
Coverage Duration	Until the end of calendar year.
Other Criteria	Initial: Atopic Dermatitis: 1) Atopic Dermatitis covering at least 10 percent of body surface area or Atopic Dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas, 2) intractable pruritus or cracking/oozing/bleeding of affected skin, 3) trial of or contraindication to one topical (corticosteroid or calcineurin inhibitor), and 4) no concurrent use with other systemic biologic/JAK inhibitor for Atopic Dermatitis. Asthma: 1) concurrent therapy with a medium, high-dose or maximally-tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, 2) one asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit within the past 12 months, or poor symptom control despite current therapy as evidenced by at least three of the following within the past 4 weeks: daytime asthma symptoms more than twice/week, any night waking due to asthma, Short-Acting Beta Agonist (SABA) reliever for symptoms more than twice/week, any activity limitation due to asthma, and 3) no concurrent use with Xolair or other Anti-IL5 biologics when used for asthma. Chronic Rhinosinusitis with Nasal Polyposis: 1) evidence of nasal polyps by direct examination, endoscopy or sinus CT scan, 2)

PA Criteria	Criteria Details
	inadequately controlled disease as determined by use of systemic steroids in the past 2 years or endoscopic sinus surgery, and 3) a 90 day trial of one topical nasal corticosteroid. Prurigo Nodularis: 1) chronic pruritis (itch more than 6 weeks), multiple pruriginous lesions, and history or sign of a prolonged scratching behavior, 2) trial of or contraindication to one topical (corticosteroid or calcipotriene). Renewal: Atopic Dermatitis: 1) improvement while on therapy, and 2) no concurrent use with other systemic biologic/JAK inhibitor for Atopic Dermatitis. Chronic Rhinosinusitis with Nasal Polyposis, Eosinophilic Esophagitis: improvement while on therapy. Asthma: 1) no concurrent use with Xolair, or other Anti-IL5 biologics for asthma, 2) continued use of ICS and one other maintenance medication, and 3) clinical response as evidenced by: (a) reduction in asthma exacerbations from baseline, (b) decreased utilization of rescue medications, (c) increase in percent predicted FEV1 from pretreatment baseline, or (d) reduction in severity or frequency of asthma-related symptoms. Prurigo Nodularis: improvement or reduction of pruritis or pruriginous lesions.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other serotonergic drugs (i.e. SSRIs, SNRIs, TCAs)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG
- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial authorization: Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy. Documentation of liver function tests, documentation of baseline forced vial capacity (FVC) greater than or equal to 50 percent of the predicted value AND documentation of percent predicted diffusing capacity of the lungs for carbon monoxide (%DLCO) greater than or equal to 30 percent.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ESTROGENS

Products Affected

- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch weekly*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol cream or Premarin Cream.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	Acute, intermittent, or postoperative pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer. Patients must remain on around-the clock opioids when taking transmucosal immediate release fentanyl.
Age Restrictions	
Prescriber Restrictions	Pain Specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FETZIMA

Products Affected

- FETZIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FIRAZYR

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documentated deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GEODON SOLUTION

Products Affected

- *ziprasidone mesylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GILENYA

Products Affected

- *fingolimod*
- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	Class III or IV heart failure, decompensated heart failure requiring hospitalization, myocardial infarction, stroke, transient ischemic attack or unstable angina within the last 6 months. Concomitant use of Class Ia or Class III anti-arrhythmic drugs. Mobitz type II second-degree or third-degree atrioventricular block, or sick-sinus syndrome unless the patient has a functional pacemaker. QT interval at baseline 500 ms or greater.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	For adults: Failure or clinically significant adverse effects to Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLATIRAMER

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLATOPA

Products Affected

- *glatopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLYBURIDE

Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: glipizide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GUANFACINE

Products Affected

- *guanfacine oral tablet*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Hypertension: Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide. ADHD: Failure or clinically significant adverse effects to two of the formulary alternatives: amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, or methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HP ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist for infantile spasm and exacerbation of multiple sclerosis
Coverage Duration	Multiple sclerosis: 21 days. For other approved indications: 28 days.
Other Criteria	For acute exacerbations of multiple sclerosis, patients must be receiving concurrent immunomodulator therapy, such as Aubagio, glatiramer, or interferon beta 1a. For all other non-neurological indications, failure or clinically significant adverse effects to other first line or standard of care therapies must be submitted.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HRM ANTIPSYCHOTICS

Products Affected

- *molindone oral tablet 10 mg, 25 mg, 5 mg*
- *thioridazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to one of the formulary alternatives: budesonide, mesalamine or sulfasalazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA PEDIATRIC

Products Affected

- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN PEDIATRIC UC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA PSORIASIS

Products Affected

- HUMIRA PEN PSOR-UVEITS-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist, Ophthalmologist, Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IMIPRAMINE

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Pediatric patients with malignant neoplasm or history of malignancy. Use for growth promotion in patients with closed epiphyses.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INGREZZA

Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: Austedo. Documentation of baseline Abnormal Involuntary Movement Scale (AIMS) scores. Reauthorization only: Documentation of positive response to medication therapy as evidenced by an improved AIMS score as compared to baseline.
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INTERFERON BETA-1A

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA HAFYERA

Products Affected

- INVEGA HAFYERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA SUSTENNA

Products Affected

- INVEGA SUSTENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral paliperidone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INVEGA TRINZA

Products Affected

- INVEGA TRINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ITRACONAZOLE

Products Affected

- *itraconazole oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with a strong CYP3A4 inhibitor or diagnosis of adrenal insufficiency
Required Medical Information	Labs within the past 30 days documenting serum potassium level of less than or equal to 5.0 mEq/L, estimated glomerular filtration rate of at least 25 mL/min/1.73m2 and urine albumin-to-creatinine ratio (UACR) of at least 30 mg/g (2) Receiving concurrent therapy with angiotensin-converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB) at maximally tolerated labeled dosage, unless contraindicated (3) medical justification that a sodium-glucose cotransport-2 (SGLT2) inhibitor (Jardiance, Invokana, Farxiga, Steglatro) AND a steroidal mineralocorticoid receptor antagonist (spironolactone, eplerenone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: Enbrel, Humira, Rinvoq, or Xeljanz IR/XR.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, fentanyl, sirolimus, etc.). History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEDIPASVIR-SOFOSBUVIR

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Hepatitis C: Failure or clinically significant adverse effects to the formulary alternative: sofosbuvir-velpatasvir (generic Epclusa).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Nivestym and Zarxio.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEUPROLIDE ACETATE

Products Affected

- *leuprolide (3 month)*
- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LEVALBUTEROL

Products Affected

- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of one of the following: Pain associated with diabetic neuropathy, Pain associated with cancer-related neuropathy, Post-herpetic neuralgia, Chronic back pain, or Osteoarthritis of the knee or hip.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LYRICA

Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postherpetic neuralgia: Failure or clinically significant adverse effects to the formulary alternative: gabapentin. Diabetic neuropathy: Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin. Fibromyalgia: Failure or clinically significant adverse effects to two of the formulary alternatives: duloxetine, gabapentin or Savella.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEPROBAMATE

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHOCARBAMOL

Products Affected

- *methocarbamol oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHOXSALEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or tazarotene.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLDOPA/HYDROCHLOROTHIAZIDE

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	Essential hypertension.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NAYZILAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NIVESTYM

Products Affected

- NIVESTYM INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Pulmonologist, Rheumatologist, Hematologist, or Otolaryngologist.
Coverage Duration	Until the end of calendar year.
Other Criteria	Asthma: Failure or clinically significant adverse effects to two of the formulary alternatives: 1) budesonide, Flovent, Arnuity Ellipta or Qvar and 2) fluticasone-salmeterol, Wixela, or Breo Ellipta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Initial authorization: Documentation of liver function tests. Reauthorization only: Documentation of positive response to therapy and documentation of liver function tests.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLANZAPINE ODT

Products Affected

- *olanzapine oral tablet,disintegrating*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral olanzapine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OLANZAPINE SOLUTION

Products Affected

- *olanzapine intramuscular*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OMNITROPE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD (initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH, glucagon, arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documented deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IFG-1/somatomedin C below age and gender adjusted normal range as provided by physicians lab. AGHD (reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORAL ANTIPSYCHOTICS

Products Affected

- *asenapine maleate*
- CAPLYTA
- FANAPT
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- *lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg*
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXBRYTA

Products Affected

- OXBRYTA ORAL TABLET 300 MG, 500 MG
- OXBRYTA ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of at least 1 episode of vaso-occlusive crisis (VOC) in the past 12 months. Hemoglobin (Hgb) greater than or equal to 5.5 and less than or equal to 10.5 g/dL. Re-authorization: Documentation of positive response to therapy.
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Stage 2 or 3 neurotrophic keratitis.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	8 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXTELLAR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG, 600 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to oxcarbazepine immediate release.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PAH

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil or tadalafil. Approve if in combination with tadalafil for treatment naive PAH patients with WHO FC II and III.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PARATHYROID HORMONE ANALOGS

Products Affected

- *teriparatide*
- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid or risedronate. Medical justification required for treatment duration beyond 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PDE5 INHIBITORS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with nitrates or PDE5 inhibitors.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM

Products Affected

- FULPHILA
- UDENYCA
- UDENYCA AUTOINJECTOR
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Nivestym and Zarxio.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Anticonvulsant: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PIMECROLIMUS

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone or fluocinonide and failure or clinically significant adverse effects to the formulary alternative: tacrolimus ointment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

POSACONAZOLE

Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PRADAXA PELLET

Products Affected

- PRADAXA ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Pediatric patients aged 3 months to less than 12 years of age.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREMARIN TABLETS

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch or estradiol tablet.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREMPRO TABLETS

Products Affected

- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch or estradiol tablet.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROCRIT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROLASTIN C

Products Affected

- PROLASTIN C 1,000 MG/20 ML VL PRICE/ONE MG,SUV
- PROLASTIN-C INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Clinical evidence of emphysema
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year
Other Criteria	Pre-treatment serum levels of alpha-1 antitrypsin (AAT) that is less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of bone mineral density (BMD) T-score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of platelet count. Thrombocytopenia in hepatitis C infection: Documentation of concurrent or planned interferon-based treatment of chronic hepatitis C.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hematologist, Hepatologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chronic immune (idiopathic) thrombocytopenia: Failure or clinically significant adverse effects to one of the formulary alternatives: dexamethasone, methylprednisolone, prednisolone or prednisone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROMETHAZINE

Products Affected

- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- *promethegan rectal suppository 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergy: Failure or clinically significant adverse effects to one of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROTRIPTYLINE

Products Affected

- *protriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	Anemia due to folate deficiency
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Prevention or treatment of nocturnal leg cramps.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary hyperlipidemia: Documentation of current LDL levels above 100mg/dL while taking maximally tolerated statin therapy and ezetimibe therapy, unless intolerant or contraindicated to statin or ezetimibe therapy. Secondary prevention of ASCVD: Documentation of at least one high risk feature: recent ACS (within the past 12 months), history of MI, history of ischemic stroke, or symptomatic peripheral arterial disease (history of claudication with ABI greater than 0.85, or previous revascularization or amputation). Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH): Documentation to confirm diagnosis by genetic testing or by clinical criteria (such as Simon Broome or the Dutch Lipid Clinic Network criteria, or history of untreated LDL-C greater than 180 mg/dL together with xanthoma or cornealis), or evidence of Familial Hypercholesterolemia in first or second-degree relatives.
Age Restrictions	
Prescriber Restrictions	Cardiologist, Endocrinologist, Lipid specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RETACRIT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone or aripiprazole. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist, dermatologist, gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Atopic dermatitis: Failure or clinically significant adverse effects to two of the formulary alternatives: cyclosporine, azathioprine, methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA
- UZEDY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RUFINAMIDE

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, clobazam or zonisamide. For Rufinamide suspension: Failure or clinically significant adverse effects to one of the formulary alternatives: Rufinamide tablet.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SAPROPTERIN

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIRTURO

Products Affected

- SIRTURO ORAL TABLET 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SKYRIZI

Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, gastroenterologist, rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOFOSBUVIR-VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SPRITAM

Products Affected

- SPRITAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to one of the formulary alternatives: budesonide, mesalamine or sulfasalazine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous F508del mutation or at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TACROLIMUS OINTMENT

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 3% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to one of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to one of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TARGRETIN

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAZORAC

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- TAZORAC TOPICAL CREAM 0.05 %
- TAZORAC TOPICAL GEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the topical formulary alternatives: calcipotriene, clobetasol or fluocinonide. Acne vulgaris: Failure or clinically significant adverse effects to two of the formulary alternatives: benzoyl peroxide/clindamycin topical, benzoyl peroxide/erythromycin topical, clindamycin topical, doxycycline oral, erythromycin topical, minocycline oral, tetracycline oral or tretinoin topical.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TECFIDERA

Products Affected

- *dimethyl fumarate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE

Products Affected

- *methyltestosterone oral capsule*
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TESTOSTERONE PUMP

Products Affected

- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: testosterone cypionate, testosterone enanthate or testosterone transdermal gel or solution.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an MAOI. Untreated or inadequately-treated depression, or current suicidality.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TIGECYCLINE

Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOBI PODHALER

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOBRAMYCIN SOLUTION

Products Affected

- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOLCAPONE

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of concurrent use with levodopa and carbidopa.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRIENTINE

Products Affected

- *trientine*

PA Criteria	Criteria Details
Exclusion Criteria	Biliary cirrhosis, rheumatoid arthritis.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: penicillamine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIHEXYPHENIDYL

Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Exclusion Criteria	Narrow angle glaucoma.
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to one of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIMIPRAMINE

Products Affected

- *trimipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRINTELLIX

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical justification specifying that TWO formulary anti-migraine drugs from different classes have been tried and failed are contraindicated, or would not be medically appropriate. Classes include: (1) Analgesics- aspirin, naproxen, ibuprofen, diclofenac, celecoxib, indomethacin, nabumetone, and (2) Triptans- sumatriptan, rizatriptan/rizatriptan ODT
Age Restrictions	
Prescriber Restrictions	Neurologist, Pain Specialist, Headache Specialist
Coverage Duration	Until the end of calendar year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VASCEPA

Products Affected

- *icosapent ethyl oral capsule 0.5 gram, 1 gram*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Reduction of risk for myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization: Documentation of maximally tolerated statin therapy, unless intolerant or contraindicated, with elevated triglycerides greater than or equal to 150 mg/dL and with either established cardiovascular disease or diabetes mellitus with two or more additional risk factors for cardiovascular disease. Severe hypertriglyceridemia: Documentation of elevated triglycerides greater than or equal to 500 mg/dL.
Age Restrictions	
Prescriber Restrictions	Lipidologist, Cardiologist, Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: omega-3 acid ethyl esters.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VEMLIDY

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hepatologist, Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	History of gallbladder removal.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the all of the formulary alternatives: dicyclomine and loperamide.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIIBRYD

Products Affected

- VIIBRYD ORAL TABLET
- VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)
- *vilazodone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, mirtazapine, or bupropion
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ

Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ulcerative colitis: Failure or clinically significant adverse effects to formulary alternative: Humira.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Hepatic encephalopathy: Failure or clinically significant adverse effects to the formulary alternative: lactulose. Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to all of the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to one of the formulary alternatives: ciprofloxacin or levofloxacin.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Asthma (Initial): Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less). Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen.
Age Restrictions	
Prescriber Restrictions	Allergist, Dermatologist, Immunologist, Pulmonologist, Otolaryngologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XYREM

Products Affected

- *sodium oxybate*
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to two of the formulary alternatives: dextroamphetamine, methylphenidate, and modafinil.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZARXIO

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotype 1a: Documentation for NS5A polymorphism testing.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral olanzapine without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INDEX