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— NOURIANZ 20MG TAB

— NOURIANZ 40MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One agent from both of the following classes was ineffective or not tolerated: a) COMT inhibitor AND b) MAO-B inhibitor.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



**Products Affected**

- NOXAFIL 300MG POWDER FOR ORAL SUSP
- *posaconazole 40mg/ml susp*

— *posaconazole 100mg dr tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– NUBEQA 300MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For metastatic hormone-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For non-metastatic castration-resistant prostate cancer: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– NUCALA 100MG INJ

– NUCALA 100MG/ML AUTO-INJECTOR

– NUCALA 100MG/ML SYRINGE

– NUCALA 40MG/0.4ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For asthma initial requests: History within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA) initial requests: All of the following: A) One of the following: 1) baseline blood eosinophil count greater than 1000 cells per microliter OR 2) baseline blood eosinophil count greater than 10% of the total leukocyte count B) Trial of oral corticosteroid therapy was ineffective or not tolerated C) One of the following was ineffective or not tolerated: a) cyclophosphamide OR b) methotrexate. For hypereosinophilic syndrome (HES) initial requests: Both of the following: A) Diagnosis confirmed by blood eosinophil count greater than 1000 cells per microliter AND B) Hypereosinophilic syndrome has persisted for at least six months. For nasal polyps initial requests: Both of the following were ineffective or not tolerated: a) an oral corticosteroid AND b) a nasal corticosteroid. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with: For asthma: an allergist, pulmonologist, or immunologist. For nasal polyps: an allergist, immunologist, or otolaryngologist. For EGPA: a rheumatology specialist, allergist, pulmonologist, or immunologist. For HES: a rheumatology specialist, allergist, pulmonologist, gastroenterologist, hematologist, or other specialist experienced in the diagnosis and treatment of HES
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

## Products Affected

– NUEDEXTA 20-10MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided (in the form of chart notes or imaging) of a structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– NUPLAZID 10MG TAB (New Starts Only)

– NUPLAZID 34MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- *armodafinil 150mg tab*
- *armodafinil 250mg tab*
- *modafinil 100mg tab*

- *armodafinil 200mg tab*
- *armodafinil 50mg tab*
- *modafinil 200mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— NUZYRA 150MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

**Products Affected**

– OCALIVA 10MG TAB

– OCALIVA 5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has one of the following: a) inadequate response to a year of therapy with ursodiol OR b) experienced intolerance to ursodiol.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



**Products Affected**

- *octreotide 0.05mg/ml inj*
- *octreotide 0.2mg/ml inj*
- *octreotide 1mg/ml inj*

- *octreotide 0.1mg/ml inj*
- *octreotide 0.5mg/ml inj*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— ODOMZO 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— OFEV 100MG CAP

— OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) For idiopathic pulmonary fibrosis initial requests: A) Diagnosis confirmed by one of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP AND B) Trial of pirfenidone was ineffective or not tolerated. 2) For systemic sclerosis-associated interstitial lung disease (ILD) initial requests: A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND B) Trial of mycophenolate mofetil was ineffective or not tolerated. 3) For chronic fibrosing ILDs with a progressive phenotype initial requests: A) Disease is progressive, defined by one of the following over the past 12 months, with no alternative explanation: i) worsening respiratory symptoms, ii) one of the following: a) forced vital capacity (FVC) decline of 5% or more OR b) corrected hemoglobin decline of 10% or more OR iii) radiological evidence of disease progression AND B) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab. 4) For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- OGSIVEO 100MG TAB 7-DAY PACK (14) (New Starts Only)
- OGSIVEO 50MG TAB (New Starts Only)

- OGSIVEO 150MG TAB 7-DAY PACK (14) (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— OJEMDA 100MG TAB (New Starts Only)

— OJEMDA 25MG/ML POWDER FOR ORAL SUSP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- OJJAARA 100MG TAB (New Starts Only)
- OJJAARA 200MG TAB (New Starts Only)

- OJJAARA 150MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- OLUMIANT 1MG TAB
- OLUMIANT 4MG TAB

- OLUMIANT 2MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For alopecia areata (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis: Prescribed by or in consultation with, a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— ONUREG 200MG TAB (New Starts Only)

— ONUREG 300MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– OPSUMIT 10MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- *fentanyl 1200mcg lozenge*
- *fentanyl 200mcg lozenge*
- *fentanyl 600mcg lozenge*

- *fentanyl 1600mcg lozenge*
- *fentanyl 400mcg lozenge*
- *fentanyl 800mcg lozenge*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 50MG/0.4ML SYRINGE

- ORENCIA 125MG/ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Humira or Hadlima, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Xeljanz, OR d) Rinvoq. For adult psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq OR i) Xeljanz. For pediatric psoriatic arthritis (initial requests): Trial of Enbrel was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, and psoriatic arthritis (adult and pediatric): Prescribed by, or in consultation with a rheumatology specialist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- ORENITRAM 0.125MG ER TAB
- ORENITRAM 1MG ER TAB
- ORENITRAM 5MG ER TAB
- ORENITRAM ER TAB MONTH 2 TITRATION KIT PACK
- ORENITRAM 0.25MG ER TAB
- ORENITRAM 2.5MG ER TAB
- ORENITRAM ER TAB MONTH 1 TITRATION KIT PACK
- ORENITRAM ER TAB MONTH 3 TITRATION KIT PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- *nitisinone 10mg cap*
- *nitisinone 2mg cap*
- ORFADIN 4MG/ML SUSP

- *nitisinone 20mg cap*
- *nitisinone 5mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— ORGOVYX 120MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- ORKAMBI 125-100MG GRANULES
- ORKAMBI 125-200MG TAB
- ORKAMBI 94-75MG GRANULES

- ORKAMBI 125-100MG TAB
- ORKAMBI 188-150MG GRANULES

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— ORSERDU 345MG TAB (New Starts Only)

— ORSERDU 86MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ESR1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

— OSPHENA 60MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Both of the following were ineffective or not tolerated: a) generic estradiol vaginal cream and b) Premarin vaginal cream.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— OTEZLA 28-DAY STARTER PACK

— OTEZLA 30MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For oral ulcers associated with Behcet's disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For oral ulcers associated with Behcet's disease (initial requests): Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test. For psoriatic arthritis and plaque psoriasis (all requests): Will not be used in combination with biologic therapy for the prescribed indication.

## Products Affected

- OXBRYTA 300MG TAB
- OXBRYTA 500MG TAB

- OXBRYTA 300MG TAB FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with crizanlizumab (Adakveo).

## Products Affected

— OXERVATE 0.002% OPHTH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Eye to be treated has never been treated with Oxervate in the past.
Age Restrictions	
Prescriber Restriction	Prescribed by an ophthalmologist.
Coverage Duration	Approved for 3 months.
Other Criteria	

**Products Affected**

- OZEMPIC 2.68MG/ML PEN INJ
- OZEMPIC 4MG/3ML PEN INJ

- OZEMPIC 2MG/3ML PEN INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- PALYNZIQ 10MG/0.5ML SYRINGE
- PALYNZIQ 20MG/ML SYRINGE

- PALYNZIQ 2.5MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with, a medical geneticist or metabolic physician.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— PANRETIN 0.1% GEL (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)

- PEMAZYRE 4.5MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate FGFR fusion or rearrangement.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

- PIQRAY 200MG DAILY DOSE PACK (New Starts Only)
- PIQRAY 300MG DAILY DOSE PACK (New Starts Only)

- PIQRAY 250MG DAILY DOSE PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA-mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)

- POMALYST 2MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

— PRALUENT 150MG/ML AUTO-INJECTOR

— PRALUENT 75MG/ML AUTO-INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of Repatha was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— PREVYMIS 240MG TAB

— PREVYMIS 480MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member will/has initiated Prevyomis within 30 days after an allogeneic hematopoietic stem cell transplant or 7 days after kidney transplant.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.
Coverage Duration	Approved for 8 months for hematopoietic stem cell transplant or 8 months for kidney transplant.
Other Criteria	

## Products Affected

- PROMACTA 12.5MG POWDER FOR ORAL SUSP
- PROMACTA 25MG POWDER FOR ORAL SUSP
- PROMACTA 50MG TAB
- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- PYRUKYND 20MG TAB (4-WEEK PACK)
- PYRUKYND 50MG TAB (4-WEEK PACK)
- PYRUKYND 5MG TAB TAPER PACK
- PYRUKYND 20MG/50MG TAB TAPER PACK
- PYRUKYND 5MG TAB (4-WEEK PACK)
- PYRUKYND 5MG/20MG TAB TAPER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Diagnosis of pyruvate kinase deficiency confirmed by genetic testing (documentation is provided). For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist or a specialist in treating pyruvate kinase deficiency.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— QINLOCK 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— *quinine sulfate 324mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	



## Products Affected

– RADICAVA 105MG/5ML SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has a score of two or greater for each individual item on the Amyotrophic Lateral Sclerosis Functional Rating Scale-Revised (ALSFRS-R). For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– RECORLEV 150MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Trial of Isturisa was ineffective or not tolerated. For continuation requests: Documentation is provided of urinary cortisol levels that show a positive clinical response.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— REGRANEX 0.01% GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 8MG/0.4ML SYRINGE

- RELISTOR 12MG/0.6ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care: Trial of lactulose was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months.
Other Criteria	

**Products Affected**

— RELTONE 200MG CAP

— RELTONE 400MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of generic ursodiol 300 mg capsule was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 420MG/3.5ML CARTRIDGE

- REPATHA 140MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- RETACRIT 10000UNIT/ML INJ
- RETACRIT 20000UNIT/ML INJ
- RETACRIT 3000UNIT/ML INJ
- RETACRIT 4000UNIT/ML INJ
- RETACRIT 20000UNIT/2ML INJ
- RETACRIT 2000UNIT/ML INJ
- RETACRIT 40000UNIT/ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– RETEVMO 40MG CAP (New Starts Only)

– RETEVMO 80MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of RET mutation or RET gene fusion.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

— *sildenafil 20mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- lenalidomide 10mg cap (New Starts Only)
- lenalidomide 2.5mg cap (New Starts Only)
- lenalidomide 25mg cap (New Starts Only)
- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- lenalidomide 15mg cap (New Starts Only)
- lenalidomide 20mg cap (New Starts Only)
- lenalidomide 5mg cap (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated. For agitation associated with dementia due to Alzheimer’s disease: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

— REYVOW 100MG TAB

— REYVOW 50MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of two different triptans was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– REZLIDHIA 150MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– REZUROCK 200MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 45MG ER TAB

- RINVOQ 30MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For ulcerative colitis (initial requests): Trial of Humira or Hadlima was ineffective or not tolerated. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of Cimzia was ineffective or not tolerated. For Crohn's disease (initial requests): Trial of Humira or Hadlima was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, or juvenile idiopathic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For Crohn's disease or ulcerative colitis: Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

## Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 50MG ORAL PELLETT (New Starts Only)

- ROZLYTREK 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



**Products Affected**

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

- RUBRACA 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- RYBELSUS 14MG TAB
- RYBELSUS 7MG TAB

- RYBELSUS 3MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— RYDAPT 25MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- *vigabatrin 500mg powder for oral soln (New Starts Only)*
- *vigadrone 500mg powder for oral soln (New Starts Only)*
- *vigpoder 500mg powder for oral soln (New Starts Only)*
- *vigabatrin 500mg tab (New Starts Only)*
- *vigadrone 500mg tab (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- SCEMBLIX 100MG TAB (New Starts Only)
- SCEMBLIX 40MG TAB (New Starts Only)

- SCEMBLIX 20MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For T315I mutation: failure of or intolerance to Iclusig required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

- SECUADO 5.7MG/24HR PATCH (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, OR g) oral asenapine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

- SIGNIFOR 0.6MG/ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- SIMPONI 100MG/ML AUTO-INJECTOR
- SIMPONI 50MG/0.5ML AUTO-INJECTOR

- SIMPONI 100MG/ML SYRINGE
- SIMPONI 50MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq, OR i) Xeljanz. For ulcerative colitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Stelara, c) Rinvoq, d) Xeljanz, or e) Skyrizi. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– SIRTURO 100MG TAB

– SIRTURO 20MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SIVEXTRO 200MG INJ

– SIVEXTRO 200MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

## Products Affected

- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 180MG/1.2ML CARTRIDGE

- SKYRIZI 150MG/ML SYRINGE
- SKYRIZI 360MG/2.4ML CARTRIDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For Crohn's disease (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– *diclofenac sodium 3% gel*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- SOMAVERT 10MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 30MG INJ

- SOMAVERT 15MG INJ
- SOMAVERT 25MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- SPRITAM 1000MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)

- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 750MG TAB FOR ORAL SUSP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of generic levetiracetam was ineffective or not tolerated
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- STELARA 45MG/0.5ML INJ
- STELARA 90MG/ML SYRINGE

- STELARA 45MG/0.5ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– STIVARGA 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SUNOSI 150MG TAB

– SUNOSI 75MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	One of the following was ineffective or not tolerated: a) modafinil OR b) armodafinil.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

**Products Affected**

- *sunitinib 12.5mg cap (New Starts Only)*
- *sunitinib 37.5mg cap (New Starts Only)*

- *sunitinib 25mg cap (New Starts Only)*
- *sunitinib 50mg cap (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SYMDEKO 50-75MG/75MG PACK

– SYMDEKO TAB 4-WEEK PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SYMPROIC 0.2MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SYNAREL 2MG/ML NASAL INHALER

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— *trientine 250mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– TABRECTA 150MG TAB (New Starts Only)

– TABRECTA 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- TAFINLAR 10MG TAB FOR ORAL SUSP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

- TAFINLAR 50MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

– TAGRISSO 40MG TAB (New Starts Only)

– TAGRISSO 80MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TALTZ 80MG/ML AUTO-INJECTOR

– TALTZ 80MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For psoriatic arthritis, non-radiographic axial spondyloarthritis and ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- TALZENNA 0.1MG CAP (New Starts Only)
- TALZENNA 0.35MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)

- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- erlotinib 100mg tab (*New Starts Only*)
- erlotinib 25mg tab (*New Starts Only*)

- erlotinib 150mg tab (*New Starts Only*)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation. For pancreatic cancer: Documentation of EGFR mutation not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

— *bexarotene 1% gel (New Starts Only)*

— *bexarotene 75mg cap (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

- TASIGNA 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

— *tazarotene 0.1% cream*

— TAZORAC 0.05% CREAM

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TAZVERIK 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TEPMETKO 225MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- testosterone 1% (12.5mg/act) gel pump
- testosterone 1% (50mg) gel packet
- testosterone 1.62% (2.5gm) gel packet
- testosterone 30mg/act topical soln

- testosterone 1% (25mg) gel packet
- testosterone 1.62% (1.25gm) gel packet
- testosterone 1.62% (20.25mg/act) gel pump

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	A) For initial requests: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. B) For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TIBSOVO 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of IDH1 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— tiopronin 100mg tab

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— tobramycin 60mg/ml inh soln

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	Approval will be based off BvD coverage determination.

**Products Affected**

— *bosentan 125mg tab*

— *bosentan 62.5mg tab*

— TRACLEER 32MG TAB FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

— TREMFYA 100MG/ML AUTO-INJECTOR

— TREMFYA 100MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis: Prescribed by, or in consultation, with a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- TRIKAFTA 100-50-75MG/150MG PACK
- TRIKAFTA 50-37.5-25MG/75MG TAB PACK

- TRIKAFTA 100-50-75MG/75MG GRANULES PACK
- TRIKAFTA 80-40-60MG/59.5MG GRANULES PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- TRULICITY 0.75MG/0.5ML AUTO-INJECTOR
- TRULICITY 3MG/0.5ML AUTO-INJECTOR

- TRULICITY 1.5MG/0.5ML AUTO-INJECTOR
- TRULICITY 4.5MG/0.5ML AUTO-INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TRUQAP 160MG TAB (New Starts Only)

– TRUQAP 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of PIK3CA, AKT1, or PTEN alteration.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TUKYSA 150MG TAB (New Starts Only)

– TUKYSA 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TURALIO 125MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– TYENNE 162MG/0.9ML AUTO-INJECTOR

– TYENNE 162MG/0.9ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Humira or Hadlima, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel OR c) Xeljanz. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— *lapatinib 250mg tab (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

- TYVASO 16-32-48MCG TITRATION PACK
- TYVASO 32-48MCG MAINTENANCE PACK
- TYVASO 48MCG INH POWDER
- TYVASO 16MCG INH POWDER
- TYVASO 32MCG INH POWDER
- TYVASO 64MCG INH POWDER

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension associated with interstitial lung disease: Interstitial lung disease confirmed by high-resolution computed tomography (HRCT).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

– UBRELVY 100MG TAB

– UBRELVY 50MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of one triptan was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— *budesonide 2mg/act rectal foam*

— *budesonide 9mg er tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of mesalamine was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

– VANFLYTA 17.7MG TAB (New Starts Only)

– VANFLYTA 26.5MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of an FLT3 internal tandem duplication (ITD) mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

- VELTASSA 25.2GM POWDER FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)

- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA TAB STARTER PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- VERQUVO 10MG TAB
- VERQUVO 5MG TAB

- VERQUVO 2.5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

- VERZENIO 100MG TAB (New Starts Only)
- VERZENIO 200MG TAB (New Starts Only)

- VERZENIO 150MG TAB (New Starts Only)
- VERZENIO 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

– LIRAGLUTIDE 6MG/ML PEN INJ

– VICTOZA 18MG/3ML PEN INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)

- VITRAKVI 20MG/ML ORAL SOLN (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of NTRK gene fusion mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- VIZIMPRO 15MG TAB (New Starts Only)
- VIZIMPRO 45MG TAB (New Starts Only)

- VIZIMPRO 30MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate EGFR mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– VONJO 100MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- VORICONAZOLE 200MG INJ
- voriconazole 40mg/ml susp

- voriconazole 200mg tab
- voriconazole 50mg tab

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 6 months.
Other Criteria	

## Products Affected

– VOSEVI 400-100-100MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Current HCV-RNA titer is provided 3) Member does not have decompensated cirrhosis 3) Previous Hepatitis C treatment(s) is provided.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist.
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on previous treatment experience as defined by current AASLD guidelines.

## Products Affected

— pazopanib 200mg tab (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– VOWST 30000000UNIT CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	For all requests: Will not be used in combination with fecal microbiota, live for rectal use (Rebyota) or bezlotoxumab (Zinplava)

## Products Affected

- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)

- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– VYNDAMAX 61MG CAP

– VYNDAQEL 20MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For Initial requests: Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining OR B) All of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 AND ii) Absence of monoclonal protein via serum protein immunofixation AND iii) Absence of monoclonal protein via urine protein immunofixation AND iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For continuation requests: Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For all requests: Will not be used in combination with Tegsedi, Onpattro, or Amvuttra.

## Products Affected

– WAKIX 17.8MG TAB

– WAKIX 4.45MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. Trial of other agents not required for patients aged 6 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

## Products Affected

– WELIREG 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- XALKORI 150MG ORAL PELLETT (New Starts Only)
- XALKORI 200MG CAP (New Starts Only)
- XALKORI 20MG ORAL PELLETT (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)
- XALKORI 50MG ORAL PELLETT (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive or ROS1-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– XATMEP 2.5MG/ML ORAL SOLN (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polyarticular juvenile idiopathic arthritis: Member is unable to swallow solid dosage forms of methotrexate. For acute lymphoblastic leukemia: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— XDEMVY 0.25% OPHTH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

- XELJANZ 10MG TAB
- XELJANZ 5MG TAB
- XELJANZ XR 22MG TAB

- XELJANZ 1MG/ML ORAL SOLN
- XELJANZ XR 11MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For ulcerative colitis (initial requests): Failure of, or intolerance to Humira or Hadlima. For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, or psoriatic arthritis: Prescribed by, or in consultation with a rheumatology specialist. For ulcerative colitis : Prescribed by, or in consultation with a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– XERMELO 250MG

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— XGEVA 120MG/1.7ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

— XIFAXAN 550MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per 1 year.

## Products Affected

- XOLAIR 150MG INJ
- XOLAIR 150MG/ML SYRINGE
- XOLAIR 300MG/2ML SYRINGE
- XOLAIR 75MG/0.5ML SYRINGE
- XOLAIR 150MG/ML AUTO-INJECTOR
- XOLAIR 300MG/2ML AUTO-INJECTOR
- XOLAIR 75MG/0.5ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initial requests: For asthma: History within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment. For nasal polyps: A) Confirmed diagnosis of nasal polyps (see other criteria) AND B) Trial of Dupixent was ineffective or not tolerated. For IgE-mediated food allergy: Confirmed diagnosis of IgE-mediated food allergy (see other criteria). For continuation requests (all diagnoses): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic idiopathic urticaria: Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For IgE-mediated food allergy: Prescribed by, or in consultation with an allergist or immunologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For asthma (initial requests): Documentation of diagnosis via skin test or RAST for specific allergy sensitivity. For nasal polyps (initial requests): Diagnosis is confirmed with a sinus CT scan AND at least four of the following apply: a) prior surgery for bilateral nasal polyposis b) evidence of type 2 inflammation c) two or more courses of oral corticosteroids required in the prior year d) significantly impaired quality of life e) significant loss of smell f) diagnosis of comorbid asthma. For IgE-mediated food allergy (initial requests): Both of the following: a) diagnosis supported by one of the following: i) positive skin prick test or ii) positive serum IgE test and b) diagnosis confirmed by one of the following: i) positive oral food challenge or ii) history of anaphylaxis to the suspected food allergen. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. For IgE-mediated

food allergy (all requests): Will not be used in combination with peanut allergen powder (Palforzia).

## Products Affected

— XOSPATA 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of FLT3 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- XPOVIO 100MG ONCE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 40MG TWICE WEEKLY CARTON (8-PACK) (New Starts Onl
- XPOVIO 60MG TWICE WEEKLY CARTON (24 PACK) (New Starts On
- XPOVIO 80MG TWICE WEEKLY CARTON (32 PACK) (New Starts On
- XPOVIO 40MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 60MG ONCE WEEKLY CARTON (4-PACK) (New Starts Only
- XPOVIO 80MG ONCE WEEKLY CARTON (8-PACK) (New Starts Only

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

- XTANDI 40MG CAP (New Starts Only)
- XTANDI 80MG TAB (New Starts Only)

- XTANDI 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications, Some Medically-Accepted Indications
Exclusion Criteria	
Required Medical Info	For metastatic castration-resistant prostate cancer and metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Both of the following were ineffective or not tolerated: a) Nubeqa and b) Erleada. For non metastatic castration sensitive prostate cancer with biochemical recurrence at high risk for metastasis: Trial of other agents not required. For homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– SODIUM OXYBATE 500MG/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. Trial of other agents not required for patients aged 7 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For excessive daytime sleepiness with narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

## Products Affected

– XYWAV 0.5GM/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. Trial of other agents not required for patients aged 7 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required. For idiopathic hypersomnia: Trial of modafinil was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For excessive daytime sleepiness with narcolepsy and idopathic hypersomnia: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

**Products Affected**

— *miglustat 100mg cap*

— *yargesa 100mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– ZAVZPRET 10MG/ACT NASAL SPRAY

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of one triptan was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

**Products Affected**

- ZEJULA 100MG TAB (New Starts Only)
- ZEJULA 300MG TAB (New Starts Only)

- ZEJULA 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of appropriate BRAF V600E or V600 mutation.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- ZEPOSIA 0.92MG CAP
- ZEPOSIA CAP 7-DAY STARTER PACK

- ZEPOSIA 28-DAY STARTER KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For ulcerative colitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Stelara, c) Rinvoq, d) Xeljanz, or e) Skyrizi. For multiple sclerosis (all requests): Trial of other agents not required. For ulcerative colitis (continuation requests): Member has benefited with use of this medication.
Age Restrictions	
Prescriber Restriction	For multiple sclerosis: Prescribed by, or in consultation with, a neurology specialist. For ulcerative colitis : Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	



## Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- *zolpidem tartrate 10mg tab*
- *zolpidem tartrate 5mg tab*

- *zolpidem tartrate 12.5mg er tab*
- *zolpidem tartrate 6.25mg er tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of trazodone.
Age Restrictions	Prior Authorization applies to members 65 years or older.
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– ZONISADE 100MG/5ML SUSP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to swallow solid dosage forms of zonisamide.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– ZORYVE 0.3% CREAM

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For plaque psoriasis: Trial of a topical corticosteroid was ineffective or not tolerated.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a dermatologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	For plaque psoriasis (all requests): Will not be used in combination with apremilast (Otezla), deucravacitinib (Sotyktu), tapinarof (Vtama) or biologic therapy for the prescribed indication.

## Products Affected

– ZTALMY 50MG/ML SUSP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of a CDKL5 gene mutation
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

- ZURZUVAE 20MG CAP (New Starts Only)
- ZURZUVAE 30MG CAP (New Starts Only)

- ZURZUVAE 25MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 1 month.
Other Criteria	

## Products Affected

– ZYDELIG 100MG TAB (New Starts Only)

– ZYDELIG 150MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	

## Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation is provided of ALK-positive disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of 1 year.
Other Criteria	