## Products Affected

- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 15mg odt (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: a) Member is unable to swallow aripiprazole tablet and b) Member is unable to use aripiprazole oral solution. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *alyq 20mg tab*
- *tadalafil 20mg tab (pah)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For all indications (all requests): Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension: Both of the following were ineffective or not tolerated: one endothelial receptor antagonist (ambrisentan, bosentan or macitentan (Opsumit) and one phosphodiesterase-5 inhibitor (sildenafil or tadalafil). For persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4): Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *everolimus 10mg tab (New Starts Only)*
- *everolimus 2mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab (New Starts Only)*
- *everolimus 7.5mg tab (New Starts Only)*
- *yulithira 2.5mg tab (New Starts Only)*
- *yulithira 7.5mg tab (New Starts Only)*
- *everolimus 2.5mg tab (New Starts Only)*
- *everolimus 3mg tab for oral susp (New Starts Only)*
- *everolimus 5mg tab for oral susp (New Starts Only)*
- *yulithira 10mg tab (New Starts Only)*
- *yulithira 5mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | FDA-approved indication or the following medically-accepted indication/regimen: Advanced renal cell carcinoma in combination with Lenvima following one prior anti-angiogenic therapy. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- AIMOVIG 140MG/ML AUTO-INJECTOR
- AIMOVIG 70MG/ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For migraine prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. For migraine prevention (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- AKEEGA 500-100MG TAB (New Starts Only)
- AKEEGA 500-50MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ALECENSA 150MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *nitazoxanide 500mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For diarrhea due to giardiasis: One of the following was ineffective or not tolerated: a) metronidazole or b) tinidazole. For diarrhea due to cryptosporidiosis: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- PROLASTIN-C 1000MG INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For alpha1-antitrypsin deficiency (all requests): Both of the following: 1) Diagnosis of congenital alpha1-antitrypsin deficiency is confirmed by both of the following: A) circulating baseline alpha1-antitrysin level is below the standard protective threshold (less than 11 micromol/L or less than 50 mg per deciliter by nephelometry) and B) high risk alpha1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) and 2) Prescriber attests that member does not have IgA deficiency with known anti-IgA antibody. |
| Age Restrictions | |
| Prescriber Restriction | For alpha1-antitrypsin deficiency: Prescribed by, or in consultation with, a pulmonologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)
- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG TAB INITIATION PACK (30) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ALYFTREK 10-50-125MG TAB
- ALYFTREK 4-20-50MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *eslicarbazepine acetate 200mg tab (New Starts Only)*
- *eslicarbazepine acetate 400mg tab (New Starts Only)*
- *eslicarbazepine acetate 600mg tab (New Starts Only)*
- *eslicarbazepine acetate 800mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– ARCALYST 220MG INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ARIKAYCE 590MG/8.4ML INH SUSP

| PA Criteria | Criteria Details |
|---|---|
| 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 infectious disease specialist or pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ATTRUBY 356MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM)(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) Non-invasive testing demonstrating all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65, ii) Absence of monoclonal protein via serum protein immunofixation, 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 ATTR-CM (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For ATTR-CM: Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of ATTR-CM. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For ATTR-CM (all requests): Will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra) or tafamidis (Vyndaqel/Vyndamax). |

Pending CMS Approval

## Products Affected

- AUGTYRO 160MG CAP (New Starts Only)
- AUGTYRO 40MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- AUSTEDO 12MG TAB
- AUSTEDO 9MG TAB
- AUSTEDO XR 18MG TAB
- AUSTEDO XR 30MG TAB
- AUSTEDO XR 42MG TAB
- AUSTEDO XR 6MG TAB
- AUSTEDO 6MG TAB
- AUSTEDO XR 12MG TAB
- AUSTEDO XR 24MG TAB
- AUSTEDO XR 36MG TAB
- AUSTEDO XR 48MG TAB
- AUSTEDO XR TAB ONCE DAILY 4 WEEK TITRATION PACK (28)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy or ii) Member is unable to switch current antidopaminergic therapy or iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy and B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or psychiatrist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- AUVELITY 105-45MG ER TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For major depressive disorder: Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, j) duloxetine, or k) vilazodone. For agitation associated with dementia due to Alzheimer disease: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- AVMAPKI/FAKZYNJA CO-PACK (66) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- AVTOZMA 162MG/0.9ML AUTO-INJECTOR
- AVTOZMA 162MG/0.9ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): Both of the following: 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, pJIA, systemic juvenile idiopathic arthritis, or 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 or rheumatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 25MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 4MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *rufinamide 200mg tab (New Starts Only)*
- *rufinamide 400mg tab (New Starts Only)*
- *rufinamide 40mg/ml oral susp (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- BENLYSTA 200MG/ML AUTO-INJECTOR
- BENLYSTA 200MG/ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For systemic lupus erythematosus (SLE)(initial requests): Two of the following were ineffective or not tolerated: a) hydroxychloroquine, b) methotrexate, c) azathioprine, d) mycophenolate or e) a corticosteroid. For lupus nephritis (initial requests): Trial of other agents not required. For all requests (all diagnoses): Prescriber attests that member does not have severe active CNS lupus. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For SLE: Prescribed by, or in consultation with, a rheumatology specialist or dermatologist. For lupus nephritis: Prescribed by, or in consultation with, a rheumatology specialist or nephrologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For SLE (initial requests): Diagnosis confirmed by one of the following: a) Anti-double stranded DNA positive, b) Low complement (C3 or C4) proteins, or c) Positive for anti-Smith antibodies. For SLE (all requests): Will not be given in combination with other biologics. For lupus nephritis (all requests): Will not be used in combination with voclosporin (Lupkynis). |

Pending CMS Approval

## Products Affected

- BESREMI 500MCG/0.5ML PEN INJ (New Starts Only)
- BESREMI 500MCG/ML SYRINGE (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For polycythemia vera: One of the following: A) Both of the following: i) High risk disease as defined by one of the following: a) Age 60 years or older or b) History of thrombosis and ii) Trial of hydroxyurea was ineffective, contraindicated, or not tolerated or B) Both of the following: i) Low risk as defined by both of the following: a) Age less than 60 years and b) No history of thrombosis. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- BOSULIF 100MG CAP (New Starts Only)
- *bosutinib 100mg tab (New Starts Only)*
- *bosutinib 500mg tab (New Starts Only)*
- BOSULIF 50MG CAP (New Starts Only)
- *bosutinib 400mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- BRAFTOVI 75MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- BRINSUPRI 10MG TAB
- BRINSUPRI 25MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For non-cystic fibrosis bronchiectasis (NCFB)(initial requests): All of the following: 1) Diagnosis of bronchiectasis confirmed by chest computed tomography scan, 2) Member does not have cystic fibrosis, and 3) Two or more pulmonary exacerbations (1 or more for patients under 18 years of age), in the last 12 months, requiring antibiotics. For NCFB (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For NCFB: Prescribed by, or in consultation with, a pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *brivaracetam 100mg tab (New Starts Only)*
- *brivaracetam 10mg/ml oral soln (New Starts Only)*
- *brivaracetam 50mg tab (New Starts Only)*
- *brivaracetam 10mg tab (New Starts Only)*
- *brivaracetam 25mg tab (New Starts Only)*
- *brivaracetam 75mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- BRUKINSA 160MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For previously treated mantle cell lymphoma: Intolerance or contraindication to therapy with Calquence. For chronic lymphocytic leukemia or small lymphocytic lymphoma: Intolerance or contraindication to therapy with both of the following: a) Calquence and b) Imbruvica. For Waldenstrom macroglobulinemia: Intolerance or contraindication to therapy with Imbruvica. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- CALQUENCE 100MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- CAPLYTA 10.5MG CAP (New Starts Only)
- CAPLYTA 21MG CAP (New Starts Only)
- CAPLYTA 42MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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, f) lurasidone, or g) asenapine. For bipolar depression: Two of the following were ineffective or not tolerated: a) lurasidone, b) quetiapine, or c) asenapine. 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *carglumic acid 200mg tab for oral susp*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- CAYSTON 75MG/ML NEB SOLN

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *tadalafil 2.5mg tab*
- *tadalafil 5mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- CIMZIA 200MG INJ
- CIMZIA 200MG/ML SYRINGE
- CIMZIA 200MG/ML SYRINGE PACK (2)
- CIMZIA 200MG/ML SYRINGE STARTER KIT (6)

| 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): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel c) Rinvoq, d) Xeljanz or e) Tyenne. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Rinvoq, or e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Starjemza or Yesintek, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq or i) Xeljanz. For plaque psoriasis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Skyrizi, e) Starjemza or Yesintek, f) Tremfya or g) Otezla. For Crohn disease (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Skyrizi, d) Rinvoq, or e) Tremfya. For Non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Xeljanz, d) Rinvoq, or e) Tyenne. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, non-radiographic axial spondyloarthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn disease: 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 | |

Pending CMS Approval

## Products Affected

- COBENFY 100-20MG CAP (New Starts Only)
- COBENFY 50-20MG CAP (New Starts Only)
- COBENFY 125-30MG CAP (New Starts Only)
- COBENFY CAP 28-DAY STARTER PACK (56) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) asenapine. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- COMETRIQ CAP 100MG DAILY DOSE PACK (56) (New Starts Only)
- COMETRIQ CAP 140MG DAILY DOSE PACK (112) (New Starts Only)
- COMETRIQ CAP 60MG DAILY DOSE PACK (84) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- COPIKTRA 15MG CAP (New Starts Only)
- COPIKTRA 25MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *ivabradine 5mg tab*
- *ivabradine 7.5mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For adults (18 years and older), one of the following: A) Member is on a maximally tolerated dose of beta blocker or B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a cardiologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- COSENTYX 150MG/ML SYRINGE
- COSENTYX 75MG/0.5ML SYRINGE
- COSENTYX SENSOREADY 150MG/ML AUTO-INJECTOR
- COSENTYX UNOREADY 300MG/2ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For ankylosing spondylitis (all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. 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 non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) Moderate to severe disease and b) Trial of one oral antibiotic 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 or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- COTELLIC 20MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | FDA-approved indication or the following medically-accepted indication/regimen: BRAF V600 mutation-positive unresectable or metastatic melanoma in combination with Zelboraf and Tecentriq (or Tecentriq Hybreza). |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- CRESEMBA 186MG CAP
- CRESEMBA 74.5MG CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | For invasive aspergillosis: 3 months. For invasive mucormycosis: 6 months. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– CYSTADROPS 0.37% OPHTH SOLN

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *pyrimethamine 25mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- DAURISMO 100MG TAB (New Starts Only)
- DAURISMO 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *metyrosine 250mg cap*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- DIACOMIT 250MG CAP (New Starts Only)
- DIACOMIT 500MG CAP (New Starts Only)
- DIACOMIT 250MG POWDER FOR ORAL SUSP (New Starts Only)
- DIACOMIT 500MG POWDER FOR ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- DIFICID 200MG TAB
- *fidaxomicin 200mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *calcipotriene 0.005% topical cream*
- *calcipotriene 0.005% topical ointment*
- CALCIPOTRIENE 0.005% TOPICAL SOLN

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- DRIZALMA 20MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 30MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 40MG DR SPRINKLE CAP (New Starts Only)
- DRIZALMA 60MG DR SPRINKLE CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For all indications: Member is unable to swallow solid dosage forms of duloxetine (Cymbalta equivalent). For major depressive disorder and generalized anxiety disorder: One of the following was ineffective or not tolerated: 1) citalopram oral solution, 2) escitalopram oral solution, 3) fluoxetine oral solution, 4) paroxetine oral suspension, or 5) sertraline oral solution. For diabetic peripheral neuropathy and fibromyalgia: One of the following was ineffective or not tolerated: 1) gabapentin oral solution or 2) pregabalin oral solution. For chronic musculoskeletal pain: Trial of additional agents (other than duloxetine [Cymbalta equivalent]) not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML AUTO-INJECTOR
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For atopic dermatitis (initial requests): Trial of a topical calcineurin inhibitor was ineffective or not tolerated (trial of other agents not required for patients under 2 years of age). For asthma (initial requests): History within the last year of at least one 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 nasal polyps (initial requests): Trial of a nasal corticosteroid was ineffective or not tolerated. For eosinophilic esophagitis (initial requests): Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis (initial requests): Trial of other agents not required. For chronic obstructive pulmonary disease (COPD)(initial requests): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving long-acting muscarinic antagonist/long-acting beta-agonist/inhaled corticosteroid maintenance triple therapy. For chronic spontaneous urticaria (initial requests): One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment. For bullous pemphigoid (BP)(initial requests): One of the following was ineffective or not tolerated: i) methotrexate, ii) azathioprine, or iii) mycophenolate mofetil. For allergic fungal rhinosinusitis (AFRS)(initial requests): Symptoms persist or recurred following sinonasal surgery despite post-operative nasal corticosteroid use. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For all indications, must be prescribed by, or in consultation with, one of the specialists listed. For atopic dermatitis, prurigo nodularis, or chronic spontaneous urticaria: Allergist, immunologist, or dermatologist. For asthma or COPD: Allergist, pulmonologist, or immunologist. For nasal polyps or AFRS: Allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Allergist or gastroenterologist. For BP: Dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis and at least two of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For asthma (initial requests): One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter or 2) Oral corticosteroid-dependent asthma. For nasal polyps (initial requests): All of the |

Pending CMS Approval

| | |
|---|---|
| | following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with nasal endoscopy or sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis (initial requests): Both of the following: 1) Endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) and 2) Symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis (initial requests): Both of the following apply: a) Diagnosis has persisted for at least 6 weeks and b) Nodules present at baseline. For COPD (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For BP (initial requests): Both of the following: a) BP Disease Area Index (BPDAI) activity score greater than or equal to 24 and b) BP is not drug-induced. For AFRS (initial requests): Both of the following: 1) Diagnosis confirmed by demonstration of all 5 of the following Bent and Kuhn major criteria: a) Confirmed Type 1 hypersensitivity, b) Nasal polyposis confirmed with nasal endoscopy or sinus CT scan, c) Presence of eosinophilic mucus, d) Characteristic CT findings of serpiginous hyperdense material with a peripheral rim of hypodense mucosa, and d) Positive fungal stains of sinonasal content and 2) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For atopic dermatitis, asthma, prurigo nodularis, or COPD (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Pending CMS Approval

## Products Affected

- EMGALITY 100MG/ML SYRINGE
- EMGALITY 120MG/ML SYRINGE
- EMGALITY 120MG/ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For migraine prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. For episodic cluster headache prophylaxis initial requests: Trial of verapamil was ineffective or not tolerated. 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 | |

Pending CMS Approval

## Products Affected

- EMSAM 12MG/24HR PATCH (New Starts Only)
- EMSAM 9MG/24HR PATCH (New Starts Only)
- EMSAM 6MG/24HR PATCH (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, j) duloxetine, or k) vilazodone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ENBREL 25MG/0.5ML INJ
- ENBREL 50MG/ML CARTRIDGE
- ENBREL SURECLICK 50MG/ML AUTO-INJECTOR
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML SYRINGE

| 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): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. 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)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For juvenile psoriatic arthritis: 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, psoriatic arthritis, juvenile psoriatic arthritis, pJIA or 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 | |

Pending CMS Approval

## Products Affected

- *l-glutamine 5gm powder for oral soln*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For sickle cell disease (initial requests): One of the following: 1) Both of the following: A) Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated and B) Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable) or 2) Prescriber is a hematologist. For sickle cell disease (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For sickle cell disease: Prescribed by, or in consultation with, a hematologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ENTYVIO 108MG/0.68ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| 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) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Rinvoq, d) Xeljanz, e) Skyrizi, or f) Tremfya. For Crohn disease (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Rinvoq, d) Skyrizi, or e) Tremfya. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For ulcerative colitis and Crohn disease: Prescribed by, or in consultation with, a gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- SOFOSBUVIR/VELPATASVIR 400-100MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | All of the following: 1) Current HCV-RNA titer is provided, 2) One of the following: a) Member does not have cirrhosis or b) Member has compensated cirrhosis and one of the following: i) Does not have genotype 3 or ii) has genotype 3 but no NS5A resistance-associated substitution Y93H, or c) Member has decompensated cirrhosis and will receive weight-based ribavirin. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist. |
| Coverage Duration | Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- EPIDIOLEX 100MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *topiramate 25mg/ml oral soln (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 topiramate. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist, headache specialist, or pain specialist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ERIVEDGE 150MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ERLEADA 240MG TAB (New Starts Only)
- ERLEADA 60MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For metastatic castration-sensitive prostate cancer: Both of the following were ineffective or not tolerated: 1) abiraterone and 2) Xtandi. For non-metastatic castration-resistant prostate cancer: Trial of Xtandi was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *pirfenidone 267mg cap*
- *pirfenidone 267mg tab*
- *pirfenidone 801mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For idiopathic pulmonary fibrosis (initial requests): Diagnosis confirmed by one of the following: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP. For idiopathic pulmonary fibrosis (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For idiopathic pulmonary fibrosis: Prescribed by, or in consultation with, a pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– EUCRISA 2% TOPICAL OINTMENT

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For atopic dermatitis: One of the following was ineffective or not tolerated: a) A topical corticosteroid or b) A topical calcineurin inhibitor. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- EVRYSDI 0.75MG/ML ORAL SOLN
- EVRYSDI 5MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For spinal muscular atrophy (SMA)(all requests): Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy. |
| Age Restrictions | |
| Prescriber Restriction | For SMA: Prescribed by a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For SMA (all requests): Will not be used in combination with nusinersen (Spinraza). |

Pending CMS Approval

## Products Affected

- EXXUA 18.2MG ER TAB (New Starts Only)
- EXXUA 36.3MG ER TAB (New Starts Only)
- EXXUA 72.6MG ER TAB (New Starts Only)
- EXXUA 18.2MG TAB TITRATION PACK (32) (New Starts Only)
- EXXUA 54.5MG ER TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, j) duloxetine, or k) vilazodone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- FANAPT 10MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- FANAPT TAB TITRATION PACK B (12) (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT TAB TITRATION PACK (8) (New Starts Only)
- FANAPT TAB TITRATION PACK C (8) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) asenapine. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- FASENRA 10MG/0.5ML SYRINGE
- FASENRA 30MG/ML SYRINGE
- FASENRA 30MG/ML AUTO-INJECTOR

| 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 one 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): Trial of oral corticosteroid therapy was ineffective or not tolerated. 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, immunologist, or pulmonologist. For EGPA: Prescribed by, or in consultation with, a rheumatology specialist, allergist, pulmonologist, or immunologist. |
| 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. |

Pending CMS Approval

## Products Affected

- FETZIMA 120MG ER CAP (New Starts Only)
- FETZIMA 40MG ER CAP (New Starts Only)
- FETZIMA ER CAP TITRATION PACK (28) (New Starts Only)
- FETZIMA 20MG ER CAP (New Starts Only)
- FETZIMA 80MG ER CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, j) duloxetine, or k) vilazodone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- FILSPARI 200MG TAB
- FILSPARI 400MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For primary immunoglobulin A nephropathy (IgAN)(initial requests): 1) Diagnosis confirmed with a kidney biopsy and 2) Member unable to adequately control proteinuria with ACE inhibitor or angiotensin receptor blocker therapy alone. For focal segmental glomerulosclerosis (FSGS)(initial requests): 1) Diagnosis confirmed with one of the following: a) Genetic test or b) Kidney biopsy, 2) Member does not have nephrotic syndrome, 3) One of the following: a) Primary FSGS and trial of high-dose glucocorticoids was ineffective or not tolerated or b) Secondary FSGS and one of the following: i) FSGS is not secondary to another condition or ii) Member failed to respond to stopping drug therapy causing FSGS or is unable to stop current drug therapy causing FSGS. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For primary IgAN or FSGS: Prescribed by, or in consultation with, a nephrologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For primary IgAN (all requests): Will not be used in combination with iptacopan (Fabhalta) or atrasentan (Vanrafia). For FSGS (all requests): Will not be used in combination with atrasentan (Vanrafia). |

Pending CMS Approval

## Products Affected

- FINTEPLA 2.2MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *icatibant 30mg/3ml syringe*

| PA Criteria | Criteria Details |
|---|---|
| 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 allergist or immunologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- FIRMAGON 120MG INJ (New Starts Only)
- FIRMAGON 80MG INJ (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- FOTIVDA 0.89MG CAP (New Starts Only)
- FOTIVDA 1.34MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- FRUZAQLA 1MG CAP (New Starts Only)
- FRUZAQLA 5MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *perampanel 0.5mg/ml oral susp (New Starts Only)*
- *perampanel 12mg tab (New Starts Only)*
- *perampanel 4mg tab (New Starts Only)*
- *perampanel 8mg tab (New Starts Only)*
- *perampanel 10mg tab (New Starts Only)*
- *perampanel 2mg tab (New Starts Only)*
- *perampanel 6mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For partial-onset seizures: Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide. For primary generalized tonic-clonic seizures: Two of the following were ineffective or not tolerated: a) lamotrigine, b) levetiracetam, c) primidone or d) topiramate. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- GAVRETO 100MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 30MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- GOMEKLI 1MG CAP (New Starts Only)
- GOMEKLI 2MG CAP (New Starts Only)
- GOMEKLI 1MG TAB FOR ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For neurofibromatosis type 1 with symptomatic plexiform neurofibromas not amenable to complete resection: Intolerance or contraindication to therapy with Koselugo. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- HADLIMA 40MG/0.4ML SYRINGE
- HADLIMA PUSHTOUCH 40MG/0.4ML AUTO-INJECTOR
- HADLIMA 40MG/0.8ML SYRINGE
- HADLIMA PUSHTOUCH 40MG/0.8ML AUTO-INJECTOR

| 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): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. 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 ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For Crohn disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) Moderate to severe disease and b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid and b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist or ophthalmologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- HAEGARDA 2000UNIT INJ
- HAEGARDA 3000UNIT INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 allergist or immunologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | Will not be used in combination with another agent for long-term prophylaxis of hereditary angioedema attacks. |

Pending CMS Approval

## Products Affected

- HERNEXEOS 60MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- HYRNUO 10MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- IBRANCE 100MG TAB (New Starts Only)
- IBRANCE 125MG TAB (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– IBTROZI 200MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ICLUSIG 10MG TAB (New Starts Only)
- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 30MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 280MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)
- IMBRUVICA 140MG TAB (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 70MG/ML ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- IMKELDI 80MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 imatinib. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– INCRELEX 40MG/4ML INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– INLURIYO 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- INLYTA 1MG TAB (New Starts Only)
- INLYTA 5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- INQOVI 35-100MG TAB PACK (5) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– INREBIC 100MG CAP (New Starts Only)

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

Pending CMS Approval

## Products Affected

– *gefitinib 250mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ISTURISA 1MG TAB
- ISTURISA 5MG TAB

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

Pending CMS Approval

## Products Affected

- ITOVEBI 3MG TAB (New Starts Only)
- ITOVEBI 9MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *ivermectin 3mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- GAMMAGARD 10GM INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAGARD 5GM/50ML INJ
- GAMMAGARD ERC 5GM/50ML INJ
- PRIVIGEN 20GM/200ML INJ
- GAMMAGARD 10GM/100ML INJ
- GAMMAGARD 5GM INJ
- GAMMAGARD ERC 10GM/100ML INJ
- GAMUNEX 1GM/10ML INJ

| PA Criteria | Criteria Details |
|---|---|
| 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. |

Pending CMS Approval

## Products Affected

- IWILFIN 192MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *deferasirox 180mg tab*
- *deferasirox 90mg tab*
- *deferasirox 360mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 hematologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- JIDEYTRO 100MG TAB (New Starts Only)
- JIDEYTRO 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *tolvaptan 15mg tab (jynarque equiv)*
- *tolvaptan 15mg/30mg tab pack (56)*
- *tolvaptan 30mg tab (jynarque equiv)*
- *tolvaptan 30mg/90mg tab pack (56)*
- *tolvaptan 15mg tab therapy pack (56)*
- *tolvaptan 15mg/45mg tab pack (56)*
- *tolvaptan 30mg/60mg tab pack (56)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For autosomal dominant polycystic kidney disease (ADPKD)(all requests): Member has an eGFR of 25 ml/min/1.73m2 or greater. |
| Age Restrictions | |
| Prescriber Restriction | For ADPKD: Prescribed by, or in consultation with, a nephrologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- KALYDECO 13.4MG ORAL GRANULES
- KALYDECO 25MG ORAL GRANULES
- KALYDECO 50MG ORAL GRANULES
- KALYDECO 150MG TAB
- KALYDECO 5.8MG ORAL GRANULES
- KALYDECO 75MG ORAL GRANULES

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- KERENDIA 10MG TAB
- KERENDIA 20MG TAB
- KERENDIA 40MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- KINERET 100MG/0.67ML SYRINGE

| 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): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima or Simlandi, c) Rinvoq, d) Xeljanz, or e) Tyenne. For cryopyrin-associated periodic syndromes and deficiency of interleukin-1 receptor antagonist (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. For cryopyrin-associated periodic syndromes: Prescribed by, or in consultation with, a dermatologist, immunologist, rheumatology specialist, or pediatrician. For deficiency of interleukin-1 receptor antagonist (DIRA): Prescribed by, or in consultation with, a provider specializing in the treatment of DIRA. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- KISQALI TAB 200MG DAILY DOSE PACK (21) (New Starts Only)
- KISQALI TAB 400MG DAILY DOSE PACK (42) (New Starts Only)
- KISQALI TAB 600MG DAILY DOSE PACK (63) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- KOMZIFTI 200MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *mifepristone 300mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- KOSELUGO 10MG CAP (New Starts Only)
- KOSELUGO 5MG SPRINKLE CAP (New Starts Only)
- KOSELUGO 25MG CAP (New Starts Only)
- KOSELUGO 7.5MG SPRINKLE CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- KRAZATI 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*
- *sapropterin 100mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a medical geneticist or metabolic physician. |
| Coverage Duration | Initial approval of 3 months. Continuing therapy approved for 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- LAZCLUZE 240MG TAB (New Starts Only)
- LAZCLUZE 80MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LENVIMA 10MG DAILY DOSE PACK (30) (New Starts Only)
- LENVIMA 14MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 20MG DAILY DOSE PACK (60) (New Starts Only)
- LENVIMA 4MG DAILY DOSE PACK (30) (New Starts Only)
- LENVIMA 12MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 18MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 24MG DAILY DOSE PACK (90) (New Starts Only)
- LENVIMA 8MG DAILY DOSE PACK (60) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LEQEMBI IQLIK 250MG/1.25ML AUTO-INJECTOR
- LEQEMBI IQLIK 360MG/1.8ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For Alzheimer disease (initial requests): Both of the following: 1) Diagnosis confirmed by presence of amyloid pathology via one of the following: a) Positron emission tomography (PET) imaging, b) Cerebrospinal fluid (CSF) test, or c) FDA-approved blood-based biomarker (BBM) test and 2) Member is appropriate to use subcutaneous maintenance dosage (at least 18 months of starting IV dosing completed). For Alzheimer disease (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For Alzheimer's disease: Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *ambrisentan 10mg tab*
- *ambrisentan 5mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- LEUKERAN 2MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LEUKINE 250MCG INJ

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

Pending CMS Approval

## Products Affected

– *lidocaine 5% patch*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All Medically-accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- LIFYORLI CAP 125MG 1-DOSE SUPPLY PACK (2) (New Starts Only)
- LIFYORLI CAP 125MG 3-DOSE SUPPLY PACK (6) (New Starts Only)
- LIFYORLI CAP 125MG 9-DOSE SUPPLY PACK (18) (New Starts Only)
- LIFYORLI CAP 150MG 1-DOSE SUPPLY PACK (3) (New Starts Only)
- LIFYORLI CAP 150MG 3-DOSE SUPPLY PACK (9) (New Starts Only)
- LIFYORLI CAP 150MG 9-DOSE SUPPLY PACK (27) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LITFULO 50MG CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For alopecia areata (initial requests): Hair loss impacts 50% or greater of the scalp. For alopecia areata (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For alopecia areata: Prescribed by or in consultation with, a dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– LIVTENCITY 200MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Prescriber attests that the medication will not be used for CMV infection prophylaxis. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist. |
| Coverage Duration | Approved for 3 months. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- LONSURF 6.14-15MG TAB (New Starts Only)
- LONSURF 8.19-20MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LORBRENA 100MG TAB (New Starts Only)
- LORBRENA 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LUMAKRAS 120MG TAB (New Starts Only)
- LUMAKRAS 240MG TAB (New Starts Only)
- LUMAKRAS 320MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LUMRYZ 4.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 6GM GRANULES FOR ORAL SUSP
- LUMRYZ 7.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 9GM GRANULES FOR ORAL SUSP
- LUMRYZ GRANULES FOR ORAL SUSP 28-DAY STARTER PACK (28

| PA Criteria | Criteria Details |
|---|---|
| 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: A nocturnal polysomnogram was used to confirm diagnosis. For cataplexy with narcolepsy: One of the following was used to confirm diagnosis: a) nocturnal polysomnogram or b) low cerebrospinal fluid orexin-A concentration. |

Pending CMS Approval

## Products Affected

- LYBALVI 10-10MG TAB (New Starts Only)
- LYBALVI 15-10MG TAB (New Starts Only)
- LYBALVI 20-10MG TAB (New Starts Only)
- LYBALVI 5-10MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) asenapine. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- LYNPARZA 100MG TAB (New Starts Only)
- LYNPARZA 150MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- LYTGOBI TAB 12MG DAILY DOSE PACK (21) (New Starts Only)
- LYTGOBI TAB 16MG DAILY DOSE PACK (28) (New Starts Only)
- LYTGOBI TAB 20MG DAILY DOSE PACK (35) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *dronabinol 10mg cap*
- *dronabinol 5mg cap*
- *dronabinol 2.5mg cap*

| PA Criteria | Criteria Details |
|---|---|
| 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. |

Pending CMS Approval

## Products Affected

- MAVYRET 100-40MG TAB
- MAVYRET 50-20MG ORAL PELLET

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) For prior treatment with a sofosbuvir-based regimen, all of the following: i) Member does not have genotype 3 and ii) No prior treatment with an NS5A inhibitor plus NS3/4A protease inhibitor regimen. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist. |
| Coverage Duration | Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- MEGESTROL ACETATE 125MG/ML ORAL SUSP
- *megestrol acetate 40mg/ml oral susp*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *megestrol acetate 20mg tab (New Starts Only)*
- *megestrol acetate 40mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- MEKINIST 0.05MG/ML ORAL SOLN (New Starts Only)
- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- MEKTOVI 15MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For acute treatment of migraine: Trial of two different triptans was ineffective or not tolerated. Trial of triptans not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders. Trial of second triptan not required for patients who did not tolerate initial triptan therapy. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- MODEYSO 125MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- MOUNJARO 10MG/0.5ML AUTO-INJECTOR
- MOUNJARO 15MG/0.5ML AUTO-INJECTOR
- MOUNJARO 5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 12.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 2.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 7.5MG/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 | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *acetylcysteine 200mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 1.25mg/3ml neb soln*
- *albuterol 5mg/ml (0.05%) neb soln*
- *amphotericin b liposomal 50mg inj*
- *aprepitant 125mg/80mg cap therapy pack (3)*
- *aprepitant 80mg cap*
- *azathioprine 50mg tab*
- *budesonide 0.5mg/2ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- *clinisol 15% inj*
- *cyclophosphamide 25mg cap*
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARSUS XR 1MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- FIASP 100UNIT/ML INJ
- GLUCOSE/SODIUM CHLORIDE 10%-0.45% INJ
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- INSULIN LISPRO 100UNIT/ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml neb soln*
- LYUMJEV 100UNIT/ML INJ
- *methylprednisolone 32mg tab*
- *acetylcysteine 400mg/4ml neb soln*
- *albuterol 0.63mg/3ml neb soln*
- *albuterol 2.5mg/3ml (0.083%) neb soln*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- *budesonide 0.25mg/2ml inh susp*
- *budesonide 1mg/2ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- *cromolyn sodium 20mg/2ml neb soln*
- *cyclophosphamide 50mg cap*
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DEXTROSE 10% INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARSUS XR 0.75MG TAB
- ENVARSUS XR 4MG TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- GLUCOSE/SODIUM CHLORIDE 10%-0.2% INJ
- *granisetron 1mg tab*
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.5mg/2.5ml (0.02%) neb soln*
- JYNNEOS 0.5ML INJ
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*

Pending CMS Approval

- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NOVOLOG 100UNIT/ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 300mg/6ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 5mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX HB 10MCG/ML SYRINGE
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML SYRINGE
- TRAVASOL 10% INJ
- *mycophenolate mofetil 200mg/ml oral susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 3mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISONE 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 2.5MG/2.5ML NEB SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML INJ
- RECOMBIVAX HB 5MCG/0.5ML SYRINGE
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TENIVAC 4-10UNIT/ML INJ
- TPN ELECTROLYTES INJ
- XATMEP 2.5MG/ML ORAL SOLN

Pending CMS Approval

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |

| | |
|---|---|
| Prescriber Restriction | |
| Coverage Duration | |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- NEMLUVIO 30MG AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For atopic dermatitis (initial requests): Trial of a topical calcineurin inhibitor was ineffective or not tolerated. For prurigo nodularis (initial 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 atopic dermatitis or prurigo nodularis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis and at least two of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For prurigo nodularis (initial requests): Both of the following apply: a) Diagnosis has persisted for at least 6 weeks and b) Nodules present at baseline. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Pending CMS Approval

## Products Affected

- NERLYNX 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *sorafenib 200mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- NEXLETOL 180MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- NEXLIZET 180-10MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ
- NORDITROPIN 15MG/1.5ML PEN INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an endocrinologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *droxidopa 100mg cap*
- *droxidopa 200mg cap*
- *droxidopa 300mg cap*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *posaconazole 100mg dr tab*
- *posaconazole 40mg/ml oral susp*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- NUBEQA 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For metastatic castration-sensitive prostate cancer: Both of the following were ineffective or not tolerated: 1) abiraterone and 2) Xtandi. For non-metastatic castration-resistant prostate cancer: Trial of Xtandi was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- NUCALA 100MG INJ
- NUCALA 100MG/ML SYRINGE
- NUCALA 100MG/ML AUTO-INJECTOR
- 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 one 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): Trial of oral corticosteroid therapy was ineffective or not tolerated. 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): Trial of a nasal corticosteroid was ineffective or not tolerated. For chronic obstructive pulmonary disease (COPD)(initial requests): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving long-acting muscarinic antagonist/long-acting beta-agonist/inhaled corticosteroid maintenance triple therapy. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For all indications, must be prescribed by, or in consultation with, one of the specialists listed. For asthma or COPD: Allergist, pulmonologist, or immunologist. For nasal polyps: Allergist, immunologist, or otolaryngologist. For EGPA: Rheumatology specialist, allergist, pulmonologist, or immunologist. For HES: 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 nasal polyps (initial requests): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with nasal endoscopy or sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For COPD (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For asthma or COPD (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Pending CMS Approval

## Products Affected

– *dextromethorphan hydrobromide/quinidine sulfate 20-10mg cap*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pseudobulbar affect (PBA)(initial requests): A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect. For PBA (continuation requests), both of the following: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect and B) Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- NUPLAZID 10MG TAB (New Starts Only)
- NUPLAZID 34MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *armodafinil 150mg tab*
- *armodafinil 250mg tab*
- *armodafinil 200mg tab*
- *armodafinil 50mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ODOMZO 200MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *nintedanib 100mg cap*
- OFEV 100MG CAP
- *nintedanib 150mg 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 | For idiopathic pulmonary fibrosis (initial requests): Diagnosis confirmed by one of the following: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP. For systemic sclerosis-associated interstitial lung disease (ILD) (initial requests): All of the following: 1) Diagnosis confirmed with documentation provided of both of the following: A) HRCT scan and B) pulmonary function tests, 2) Trial of mycophenolate mofetil was ineffective or not tolerated and 3) Trial of Tyenne was ineffective or not tolerated. For chronic fibrosing ILDs with a progressive phenotype (initial requests): All of the following: 1) Disease is progressive, as defined by one of the following over the past 12 months, with no alternative explanation: A) Worsening respiratory symptoms, B) One of the following: i) Forced vital capacity (FVC) decline of 5% or more or ii) Absolute decline in, and diffusing capacity of, the lung for carbon monoxide (corrected for hemoglobin) of 10% predicted or greater or C) Radiological evidence of disease progression and 2) 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, or vii) rituximab. For continuation requests (all diagnoses): Member has benefited with use of this medication. Requests for brand name Ofev for all indications (all requests): Intolerance to therapy with generic nintedanib. |
| Age Restrictions | |
| Prescriber Restriction | For idiopathic pulmonary fibrosis and chronic fibrosing ILDs with a progressive phenotype: Prescribed by, or in consultation with, a pulmonologist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist or rheumatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- OGSIVEO 100MG TAB 7-DAY PACK (14) (New Starts Only)
- OGSIVEO 150MG TAB 7-DAY PACK (14) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OJEMDA 100MG TAB PACK (400MG ONCE WEEKLY) (16) (New Star
- OJEMDA 100MG TAB PACK (500MG ONCE WEEKLY) (20) (New Star
- OJEMDA 100MG TAB PACK (600MG ONCE WEEKLY) (24) (New Star
- OJEMDA 25MG/ML POWDER FOR ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OJJAARA 100MG TAB (New Starts Only)
- OJJAARA 150MG TAB (New Starts Only)
- OJJAARA 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OLUMIANT 1MG TAB
- OLUMIANT 2MG TAB
- OLUMIANT 4MG 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): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Rinvoq, d) Xeljanz or e) Tyenne. For alopecia areata (initial requests): Hair loss impacts 50% or greater of the scalp. 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. For alopecia areata: Prescribed by or in consultation with, a dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- OMNITROPE 10MG/1.5ML CARTRIDGE
- OMNITROPE 5MG/1.5ML CARTRIDGE
- OMNITROPE 5.8MG INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an endocrinologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OPIPZA 10MG ORAL FILM (New Starts Only)
- OPIPZA 5MG ORAL FILM (New Starts Only)
- OPIPZA 2MG ORAL FILM (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: A) Member is unable to swallow aripiprazole tablet and B) Member is unable to use aripiprazole oral solution. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *macitentan 10mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ORENCIA 125MG/ML SYRINGE
- ORENCIA 87.5MG/0.7ML SYRINGE
- ORENCIA 50MG/0.4ML SYRINGE
- ORENCIA CLICKJECT 125MG/ML AUTO-INJECTOR

| 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): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima or Simlandi, c) Rinvoq, d) Xeljanz, or e) Tyenne. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Xeljanz, d) Rinvoq, or e) Tyenne. For adult psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Cosentyx, d) Starjemza or Yesintek, 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, pJIA or psoriatic arthritis (adult and pediatric): Prescribed by, or in consultation with a rheumatology specialist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ORGOVYX 120MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ORKAMBI 125-100MG ORAL GRANULES
- ORKAMBI 125-200MG TAB
- ORKAMBI 94-75MG ORAL GRANULES
- ORKAMBI 125-100MG TAB
- ORKAMBI 188-150MG ORAL GRANULES

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ORSERDU 345MG TAB (New Starts Only)
- ORSERDU 86MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OTEZLA 10/20/30MG TAB 28-DAY STARTER PACK (55)
- OTEZLA 20MG TAB
- OTEZLA XR 75MG TAB
- OTEZLA 10/20MG TAB 28-DAY STARTER PACK (55)
- OTEZLA 30MG TAB
- OTEZLA/OTEZLA XR 28-DAY 10/20/30/75MG STARTER PACK (41)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For oral ulcers associated with Behcet disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (all requests): Trial of other agents not required. 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 with mild disease or 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 disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist (dermatologist not required for mild plaque psoriasis). |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For oral ulcers associated with Behcet 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. |

Pending CMS Approval

## Products Affected

- OZEMPIC 2MG/3ML PEN INJ
- OZEMPIC 4MG/3ML PEN INJ
- OZEMPIC 8MG/3ML PEN INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- OZEMPIC 1.5MG TAB
- OZEMPIC 4MG TAB
- OZEMPIC 9MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– PANRETIN 0.1% TOPICAL GEL (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- PEMAZYRE 13.5MG TAB (New Starts Only)
- PEMAZYRE 9MG TAB (New Starts Only)
- PEMAZYRE 4.5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- PIQRAY TAB 200MG DAILY DOSE PACK (28) (New Starts Only)
- PIQRAY TAB 250MG DAILY DOSE PACK (56) (New Starts Only)
- PIQRAY TAB 300MG DAILY DOSE PACK (56) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *pomalidomide 1mg cap (New Starts Only)*
- *pomalidomide 2mg cap (New Starts Only)*
- *pomalidomide 3mg cap (New Starts Only)*
- *pomalidomide 4mg cap (New Starts Only)*
- POMALYST 1MG CAP (New Starts Only)
- POMALYST 2MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | FDA-approved indication or one of the following medically-accepted indications/regimens: Multiple myeloma and one of the following: a) In combination with Darzalex and trial of at least two prior therapies including lenalidomide and a proteasome inhibitor or b) In combination with Darzalex Faspro and trial of at least one prior therapy including lenalidomide and a proteasome inhibitor. Requests for brand name Pomalyst for all indications (new starts only): Intolerance to therapy with generic pomalidomide. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- PREVYMIS 120MG ORAL PELLET
- PREVYMIS 240MG TAB
- PREVYMIS 480MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Member will/has initiated Prevymis 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 | |

Pending CMS Approval

## Products Affected

- *eltrombopag olamine 12.5mg powder for oral susp*
- *eltrombopag olamine 25mg powder for oral susp*
- *eltrombopag olamine 50mg tab*
- *eltrombopag olamine 12.5mg tab*
- *eltrombopag olamine 25mg tab*
- *eltrombopag olamine 75mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *modafinil 100mg tab*
- *modafinil 200mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *mercaptopurine 2000mg/100ml oral susp (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 mercaptopurine. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- QINLOCK 50MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *quinine sulfate 324mg cap*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- QULIPTA 10MG TAB
- QULIPTA 30MG TAB
- QULIPTA 60MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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) Aimovig and B) Emgality. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- RADICAVA 105MG/5ML ORAL SUSP

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

Pending CMS Approval

## Products Affected

- RALDESY 10MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 trazodone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REDEMPLO 25MG/0.5ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For familial chylomicronemia syndrome (FCS)(initial requests): Both of the following: 1) One of the following: a) FCS confirmed by genetic test results or b) FCS diagnosis supported by North American FCS (NAFCS) score greater than or equal to 45 and 2) Pretreatment labs show a fasting triglyceride level greater than or equal to 880 mg/dL. For FCS (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For FCS: Prescribed by, or in consultation with, an endocrinologist, cardiologist, gastroenterologist, or specialist experienced in treating severe hypertriglyceridemia. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REPATHA 140MG/ML SYRINGE
- REPATHA SURECLICK 140MG/ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## 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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- RETEVMO 120MG TAB (New Starts Only)
- RETEVMO 40MG TAB (New Starts Only)
- RETEVMO 160MG TAB (New Starts Only)
- RETEVMO 80MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *tretinoin 0.01% topical gel*
- *tretinoin 0.025% topical gel*
- *tretinoin 0.025% topical cream*
- *tretinoin 0.1% topical cream*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *sildenafil 20mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REVCOVI 2.4MG/1.5ML INJ

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For adenosine deaminase severe combined immune deficiency (ADA-SCID)(initial requests): Diagnosis confirmed by one of the following: a) Absent or very low (less than 1 percent of normal) ADA activity in red blood cells, b) Increased levels of deoxyadenosine triphosphate in erythrocyte lysates compared to laboratory standards, c) Significantly decreased concentration of adenosine triphosphate in red blood cells, d) Absent or very low (less than 5 percent of normal) levels of s-adenosylhomocysteine hydrolase in red blood cells, e) Elevated levels of 2-deoxyadensoine in plasma, urine, or dried blood spots, or f) Presence of biallelic pathogenic mutations in the ADA gene. For ADA-SCID (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For ADA-SCID: Prescribed by, or in consultation with, an immunologist or provider who specializes ADA-SCID. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *lenalidomide 10mg cap (New Starts Only)*
- *lenalidomide 2.5mg cap (New Starts Only)*
- *lenalidomide 25mg cap (New Starts Only)*
- *lenalidomide 15mg cap (New Starts Only)*
- *lenalidomide 20mg cap (New Starts Only)*
- *lenalidomide 5mg cap (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | FDA-approved indication or one of the following medically-accepted indications/regimens: 1) Relapsed or refractory follicular lymphoma in combination with Epkinly and rituximab, 2) Multiple myeloma and one of the following: a) Newly diagnosed, ineligible for autologous stem cell transplant, and in combination with Darzalex (or Darzalex Faspro) and dexamethasone, b) Relapsed or refractory, at least one prior therapy, and in combination with Darzalex (or Darzalex Faspro) and dexamethasone, c) Induction and consolidation, newly diagnosed, eligible for autologous stem cell transplant, and in combination with Darzalex Faspro, bortezomib, and dexamethasone, d) Newly diagnosed, ineligible for autologous stem cell transplant, and in combination with Darzalex Faspro, bortezomib, and dexamethasone, or e) At least one prior therapy and in combination with Ninlaro and dexamethasone or 3) Relapsed or refractory large B-cell lymphoma in combination with brentuximab and rituximab with trial of at least two prior systemic therapies and not eligible for autologous stem cell transplant or chimeric antigen receptor T-cell therapy. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REVUFORJ 110MG TAB (New Starts Only)
- REVUFORJ 25MG TAB (New Starts Only)
- REVUFORJ 160MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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, f) lurasidone, or g) asenapine. For major depressive disorder: Trial of aripiprazole was ineffective or not tolerated. For agitation associated with dementia due to Alzheimer disease: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REZDIFFRA 100MG TAB
- REZDIFFRA 80MG TAB
- REZDIFFRA 60MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For metabolic dysfunction-associated steatohepatitis (MASH)(initial requests): 1) Stage F2 or F3 fibrosis confirmed by one of the following: a) Liver biopsy or b) Both of the following: i) One of the following: Fibrosis-4 score greater than or equal to 1.3 or enhanced liver fibrosis score greater than or equal to 9.2 and ii) One of the following: Vibration-controlled transient elastography greater than or equal to 8 kPa or magnetic resonance elastography greater than or equal to 3.1 kPa, 2) Attestation that the medication will be used in conjunction with diet and exercise, and 3) Trial of Wegovy injection was ineffective or not tolerated. For MASH (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hepatologist or gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- REZLIDHIA 150MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- REZUROCK 200MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- RHAPSIDO 25MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For chronic spontaneous urticaria (initial requests): One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment. For chronic spontaneous urticaria (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For chronic spontaneous urticaria: Prescribed by, or in consultation with, an allergist, dermatologist, or immunologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- RINVOQ 15MG ER TAB
- RINVOQ 30MG ER TAB
- RINVOQ 1MG/ML ORAL SOLN
- RINVOQ 45MG 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) Hadlima or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For atopic dermatitis (initial requests): Trial of a topical calcineurin inhibitor was ineffective or not tolerated. For ulcerative colitis (initial requests): One of the following preferred systemic agents was ineffective or not tolerated: a) a TNF antagonist, b) Starjemza or Yesintek, c) Skyrizi, or d) Tremfya. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of Cimzia was ineffective or not tolerated. For Crohn disease (initial requests): One of the following preferred systemic agents was ineffective or not tolerated: a) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Skyrizi, or d) Tremfya. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For giant cell arteritis (initial 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, psoriatic arthritis, ankylosing spondylitis, pJIA, non-radiographic axial spondyloarthritis, or giant cell arteritis: 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 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 and at least two 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. |

Pending CMS Approval

## Products Affected

- ROMVIMZA 14MG CAP (New Starts Only)
- ROMVIMZA 20MG CAP (New Starts Only)
- ROMVIMZA 30MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ROZLYTREK 100MG CAP (New Starts Only)
- ROZLYTREK 200MG CAP (New Starts Only)
- ROZLYTREK 50MG ORAL PELLET (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 250MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- RYDAPT 25MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *octreotide 0.05mg/ml inj*
- *octreotide 0.1mg/ml inj*
- *octreotide 0.2mg/ml inj*
- *octreotide 0.5mg/ml inj*
- *octreotide 1mg/ml inj*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SANTYL 250UNIT/GM TOPICAL OINTMENT

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SCEMBLIX 100MG TAB (New Starts Only)
- SCEMBLIX 20MG TAB (New Starts Only)
- SCEMBLIX 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SECUADO 3.8MG/24HR PATCH (New Starts Only)
- SECUADO 5.7MG/24HR PATCH (New Starts Only)
- SECUADO 7.6MG/24HR PATCH (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.6MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SIMLANDI 20MG/0.2ML SYRINGE
- SIMLANDI 40MG/0.4ML SYRINGE
- SIMLANDI 40MG/0.4ML AUTO-INJECTOR
- SIMLANDI 80MG/0.8ML AUTO-INJECTOR

| 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): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. 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 ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For Crohn disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) Moderate to severe disease and b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid and b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist or ophthalmologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- SIRTURO 100MG TAB
- SIRTURO 20MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SKYRIZI 150MG/ML AUTO-INJECTOR
- SKYRIZI 180MG/1.2ML CARTRIDGE
- SKYRIZI 55MG/0.37ML SYRINGE
- SKYRIZI 150MG/ML SYRINGE
- SKYRIZI 360MG/2.4ML CARTRIDGE

| PA Criteria | Criteria Details |
|---|---|
| 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 (all requests): Trial of other agents not required. For Crohn 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 psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Crohn disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *diclofenac sodium 3% topical gel*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SOLTAMOX 10MG/5ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 tamoxifen. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- SOMAVERT 10MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 25MG INJ
- SOMAVERT 30MG INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SPRITAM 250MG TAB FOR ORAL SUSP (New Starts Only)
- SPRITAM 500MG TAB FOR ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 levetiracetam (Keppra equivalent). |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *dasatinib 100mg tab (New Starts Only)*
- *dasatinib 20mg tab (New Starts Only)*
- *dasatinib 70mg tab (New Starts Only)*
- *dasatinib 140mg tab (New Starts Only)*
- *dasatinib 50mg tab (New Starts Only)*
- *dasatinib 80mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For Crohn 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 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 | |

Pending CMS Approval

## Products Affected

- STIVARGA 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SUBVENITE 10MG/ML ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: A) Member is unable to swallow lamotrigine tablet and B) Member is unable to use lamotrigine chewable dispersible tablet. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- SUNOSI 150MG TAB
- SUNOSI 75MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | A nocturnal polysomnogram was used to confirm diagnosis. |

Pending CMS Approval

## Products Affected

- *sunitinib malate 12.5mg cap (New Starts Only)*
- *sunitinib malate 25mg cap (New Starts Only)*
- *sunitinib malate 37.5mg cap (New Starts Only)*
- *sunitinib malate 50mg cap (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SYMDEKO TAB 4-WEEK PACK (56)
- SYMDEKO TAB 50-75MG/75MG PACK (56)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- SYMPAZAN 10MG ORAL FILM (New Starts Only)
- SYMPAZAN 5MG ORAL FILM (New Starts Only)
- SYMPAZAN 20MG ORAL FILM (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: a) Member is unable to swallow solid dosage forms of clobazam and b) Member is unable to use clobazam oral suspension. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *trientine 250mg cap*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TABRECTA 150MG TAB (New Starts Only)
- TABRECTA 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TAFINLAR 10MG TAB FOR ORAL SUSP (New Starts Only)
- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TALZENNA 0.1MG CAP (New Starts Only)
- TALZENNA 0.25MG CAP (New Starts Only)
- TALZENNA 0.35MG CAP (New Starts Only)
- TALZENNA 0.5MG CAP (New Starts Only)
- TALZENNA 0.75MG CAP (New Starts Only)
- TALZENNA 1MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *erlotinib 100mg tab (New Starts Only)*
- *erlotinib 150mg tab (New Starts Only)*
- *erlotinib 25mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *bexarotene 1% topical gel (New Starts Only)*
- *bexarotene 75mg cap (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TARPEYO 4MG DR CAP

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For primary immunoglobulin A nephropathy (IgAN)(initial requests): 1) Diagnosis confirmed with a kidney biopsy and 2) Member unable to adequately control proteinuria with ACE Inhibitor or angiotensin receptor blocker therapy alone. For primary IgAN (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For primary IgAN: Prescribed by, or in consultation with, an nephrologist. |
| Coverage Duration | Approved for 9 months. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *nilotinib 150mg cap (New Starts Only)*
- *nilotinib 200mg cap (New Starts Only)*
- *nilotinib 50mg cap (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *tazarotene 0.1% topical cream*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TEPMETKO 225MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *testosterone 1% (12.5mg/act) topical gel pump*
- *testosterone 1% (50mg/5gm) topical gel packet*
- *testosterone 30mg/act topical soln*
- *testosterone 1% (25mg/2.5gm) topical gel packet*
- *testosterone 1.62% (20.25mg/act) topical gel pump*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests (all diagnoses): A) Prescriber attests that hypogonadism is not age-related and B) Documentation is provided of two morning fasting testosterone levels (from two separate days) that fall below the normal range for a healthy adult male. 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 | |

Pending CMS Approval

## Products Affected

- TIBSOVO 250MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– TOBI PODHALER 28MG PACK (224)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of generic nebulized tobramycin solution was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *tobramycin 300mg/5ml neb soln*

| PA Criteria | Criteria Details |
|---|---|
| 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. |

Pending CMS Approval

## Products Affected

- *bosentan 125mg tab*
- *bosentan 62.5mg tab*

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- TREMFYA 100MG/ML AUTO-INJECTOR
- TREMFYA 200MG/2ML AUTO-INJECTOR
- TREMFYA 200MG/2ML SYRINGE
- TREMFYA 100MG/ML SYRINGE
- TREMFYA 200MG/2ML AUTO-INJECTOR INDUCTION PACK FOR C

| PA Criteria | Criteria Details |
|---|---|
| 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 (all requests): Trial of other agents not required. For Crohn 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 psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Crohn disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- TRIKAFTA 100-50-75MG/150MG TAB PACK (84)
- TRIKAFTA 50-37.5-25MG/75MG TAB PACK (84)
- TRIKAFTA 100-50-75MG/75MG ORAL GRANULES PACK (56)
- TRIKAFTA 80-40-60MG/59.5MG ORAL GRANULES PACK (56)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TRINTELLIX 10MG TAB (New Starts Only)
- TRINTELLIX 5MG TAB (New Starts Only)
- TRINTELLIX 20MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, j) duloxetine, or k) vilazodone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- TRULICITY 0.75MG/0.5ML AUTO-INJECTOR
- TRULICITY 1.5MG/0.5ML AUTO-INJECTOR
- TRULICITY 3MG/0.5ML AUTO-INJECTOR
- TRULICITY 4.5MG/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 | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- TRUQAP 160MG TAB (New Starts Only)
- TRUQAP 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TRYNGOLZA 50MG/0.8ML AUTO-INJECTOR
- TRYNGOLZA 80MG/0.8ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For familial chylomicronemia syndrome (FCS)(initial requests): Both of the following: 1) One of the following: a) FCS confirmed by genetic test results or b) FCS diagnosis supported by North American FCS (NAFCS) score greater than or equal to 45 and 2) Pretreatment labs show a fasting triglyceride level greater than or equal to 880 mg/dL. For FCS (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For FCS: Prescribed by, or in consultation with, an endocrinologist, cardiologist, gastroenterologist, or specialist experienced in treating severe hypertriglyceridemia. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TURALIO 125MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- TYENNE 162MG/0.9ML AUTO-INJECTOR
- TYENNE 162MG/0.9ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): Both of the following: 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, pJIA, systemic juvenile idiopathic arthritis, or 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 or rheumatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *lapatinib ditosylate 250mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- UBRELVY 100MG TAB
- UBRELVY 50MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For acute treatment of migraine: Trial of one triptan was ineffective or not tolerated. Trial of triptan not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– *budesonide 9mg er tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VALCHLOR 0.016% TOPICAL GEL (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VANFLYTA 17.7MG TAB (New Starts Only)
- VANFLYTA 26.5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VELSIPITY 2MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Rinvoq, d) Xeljanz, e) Skyrizi, or f) Tremfya. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA TAB STARTER PACK (42) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VERQUVO 10MG TAB
- VERQUVO 5MG TAB
- VERQUVO 2.5MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VERSACLOZ 50MG/ML ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: a) Member is unable to swallow clozapine tablet and b) Member is unable to use clozapine ODT. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## 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)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- *voriconazole 200mg inj*
- *voriconazole 40mg/ml oral susp*
- *voriconazole 200mg tab*
- *voriconazole 50mg tab*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VIGAFYDE 100MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following: a) Member is unable to swallow vigabatrin tablet and b) Member is unable to use vigabatrin powder for oral solution. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- VITRAKVI 100MG CAP (New Starts Only)
- VITRAKVI 25MG CAP (New Starts Only)
- VITRAKVI 20MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VONJO 100MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) Jakafi, b) Inrebic, or c) Ojjaara. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- VORANIGO 10MG TAB (New Starts Only)
- VORANIGO 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VOSEVI 400-100-100MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) Previous hepatitis C treatments are provided. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a gastroenterologist, hepatologist, 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. |

Pending CMS Approval

## Products Affected

– *pazopanib 200mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- VOWST 30000000UNIT CAP

| PA Criteria | Criteria Details |
|---|---|
| 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). |

Pending CMS Approval

## Products Affected

- VRAYLAR 0.5MG CAP (New Starts Only)
- VRAYLAR 0.75MG CAP (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) asenapine. 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 | |

Pending CMS Approval

## Products Affected

- WEGOVY 0.25MG/0.5ML AUTO-INJECTOR
- WEGOVY 1.7MG/0.75ML AUTO-INJECTOR
- WEGOVY 2.4MG/0.75ML AUTO-INJECTOR
- WEGOVY 0.5MG/0.5ML AUTO-INJECTOR
- WEGOVY 1MG/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 cardiovascular (CV) risk reduction (all requests): 1) One of the following: a) Body mass index (BMI) is greater than or equal to 27 (new starts) or b) Pre-treatment BMI was greater than or equal to 27 and 2) Established CV disease with one of the following: a) Prior myocardial infarction, b) Prior stroke, c) Symptomatic peripheral arterial disease, d) Unstable angina, or e) Prior cardiac revascularization. For metabolic dysfunction-associated steatohepatitis (MASH)(initial requests): 1) Stage F2 or F3 fibrosis confirmed by one of the following: a) Liver biopsy or b) Both of the following: i) One of the following: Fibrosis-4 score greater than or equal to 1.3 or enhanced liver fibrosis score greater than or equal to 9.2 and ii) One of the following: Vibration-controlled transient elastography greater than or equal to 8 kPa or magnetic resonance elastography greater than or equal to 3.1 kPa and 2) Attestation that the medication will be used in conjunction with diet and exercise. For MASH (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For MASH: Prescribed by, or in consultation with, a hepatologist or gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- WEGOVY 1.5MG TAB
- WEGOVY 4MG TAB
- WEGOVY 25MG TAB
- WEGOVY 9MG TAB

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For cardiovascular (CV) risk reduction (all requests): 1) One of the following: a) Body mass index (BMI) is greater than or equal to 27 (new starts) or b) Pre-treatment BMI was greater than or equal to 27 and 2) Established CV disease with one of the following: a) Prior myocardial infarction, b) Prior stroke, c) Symptomatic peripheral arterial disease, d) Unstable angina, or e) Prior cardiac revascularization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- WELIREG 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- WINREVAIR 45MG INJ
- WINREVAIR 60MG INJ
- WINREVAIR 45MG INJ (2 VIAL PACK)
- WINREVAIR 60MG INJ (2 VIAL PACK)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For pulmonary arterial hypertension (all requests): Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- XCOPRI 100MG TAB (New Starts Only)
- XCOPRI 200MG TAB (New Starts Only)
- XCOPRI 50MG TAB (New Starts Only)
- XCOPRI TAB 12.5/25MG TITRATION PACK (28) (New Starts Only)
- XCOPRI TAB 150/200MG TITRATION PACK (28) (New Starts Only)
- XCOPRI 150MG TAB (New Starts Only)
- XCOPRI 25MG TAB (New Starts Only)
- XCOPRI TAB 100/150MG MAINTENANCE PACK (56) (New Starts Onl
- XCOPRI TAB 150/200MG PACK (56) (New Starts Only)
- XCOPRI TAB 50/100MG TITRATION PACK (28) (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate or g) lacosamide. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

– XDEMVY 0.25% OPHTH SOLN

| PA Criteria | Criteria Details |
|---|---|
| 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 optometrist or ophthalmologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- *tofacitinib 10mg tab*
- *tofacitinib 1mg/ml oral soln*
- *tofacitinib 5mg tab*
- *tofacitinib 11mg er tab*
- *tofacitinib 22mg 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) Hadlima or Simlandi or b) Enbrel. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ulcerative colitis (initial requests): Trial of a TNF antagonist 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, pJIA, 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 | |

Pending CMS Approval

## Products Affected

– XERMELO 250MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- XIFAXAN 550MG TAB

| PA Criteria | Criteria Details |
|---|---|
| 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. |

Pending CMS Approval

## 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 asthma (initial requests): History within the last year of at least one 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 spontaneous urticaria (initial requests): Both of the following: 1) One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment and 2) Both of the following were ineffective or not tolerated: a) Dupixent and b) Rhapsido. For nasal polyps (initial requests): Both of the following were ineffective or not tolerated: a) Dupixent and b) Nucala. For IgE-mediated food allergy (initial 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 asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic spontaneous 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): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with nasal endoscopy or sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). 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 |

Pending CMS Approval

| | |
|---|---|
| | 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). |

Pending CMS Approval

## Products Affected

- XOSPATA 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- XPOVIO TAB 100MG ONCE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 40MG TWICE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 60MG TWICE WEEKLY CARTON (24) (New Starts Only
- XPOVIO TAB 80MG ONCE WEEKLY CARTON (8) (New Starts Only)
- XPOVIO TAB 40MG ONCE WEEKLY CARTON (16) (New Starts Only)
- XPOVIO TAB 60MG ONCE WEEKLY CARTON (4) (New Starts Only)
- XPOVIO TAB 80MG ONCE WEEKLY CARTON (4) (New Starts Only)
- XPOVIO TAB 80MG TWICE WEEKLY CARTON (32) (New Starts Only

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | One of the following: 1) FDA-approved indication: a) For metastatic castration-resistant prostate cancer and metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated, b) For non-metastatic castration-resistant prostate cancer: Trial of other agents not required, or c) For non metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis: Trial of other agents not required, or 2) Medically-accepted indication/regimen: Homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- XTRENBO 120MG/1.7ML INJ

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *lidocaine 5% topical ointment*

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

– *sodium oxybate 500mg/ml oral soln*

| PA Criteria | Criteria Details |
|---|---|
| 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: A nocturnal polysomnogram was used to confirm diagnosis. For cataplexy with narcolepsy: One of the following was used to confirm diagnosis: a) nocturnal polysomnogram or b) low cerebrospinal fluid orexin-A concentration. |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For Crohn 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 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 | |

Pending CMS Approval

## Products Affected

- ZAVZPRET 10MG/ACT NASAL SPRAY

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For acute treatment of migraine: Trial of one triptan was ineffective or not tolerated. Trial of triptan not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ZEJULA 100MG TAB (New Starts Only)
- ZEJULA 200MG TAB (New Starts Only)
- ZEJULA 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ZELBORAF 240MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications, Some Medically-Accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | FDA-approved indication or one of the following medically-accepted indications/regimens: Unresectable or metastatic melanoma and one of the following: a) BRAF V600E or V600K mutation and in combination with Cotellic or b) BRAF V600 mutation-positive and in combination with Cotellic and Tecentriq (or Tecentriq Hybreza). |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ZENBEXUS 0.75MG CAP (New Starts Only)
- ZENBEXUS 1MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ZOLINZA 100MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| 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 | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ZTALMY 50MG/ML ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)(all requests): Documentation is provided of a CDKL5 gene mutation. |
| Age Restrictions | |
| Prescriber Restriction | For CDD: Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval

## Products Affected

- ZURZUVAE 20MG CAP (New Starts Only)
- ZURZUVAE 25MG CAP (New Starts Only)
- ZURZUVAE 30MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ZYKADIA 150MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|---|---|
| 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 | |

Pending CMS Approval

## Products Affected

- ZYMFENTRA 120MG/ML PEN INJ
- ZYMFENTRA 120MG/ML SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| 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) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Rinvoq, d) Xeljanz, e) Skyrizi, or f) Tremfya. For Crohn disease (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Starjemza or Yesintek, c) Rinvoq, d) Skyrizi, or e) Tremfya. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For ulcerative colitis and Crohn disease: Prescribed by, or in consultation with, a gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Pending CMS Approval