PA Criteria

Prior Authorization Group	ABIRATERONE
Drug Names	ABIRATERONE ACETATE, ZYTIGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ACITRETIN
Drug Names	ACITRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AFINITOR
Drug Names	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), lymphangioleiomyomatosis, gastrointestinal stromal tumors, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, and 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AIMOVIG
Drug Names	AIMOVIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial 3 months, Reauthorization Plan Year
Other Criteria	-

Prior Authorization Group	ALDURAZYME
Drug Names	ALDURAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mucopolysaccharidosis I: diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer, brain metastases from ALK-positive non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALOSETRON
Drug Names	ALOSETRON HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, PROLASTIN-C, ZEMAIRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from NSCLC.
Exclusion Criteria	-
Required Medical Information	For brain metastases from NSCLC: disease is ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ANADROL
Drug Names	ANADROL-50
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cachexia associated with AIDS (HIV-wasting)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	APOKYN
Drug Names	APOKYN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	-
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in members initiating or continuing urate-lowering therapy (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	-

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ATYPICAL ANTIPSYCHOTICS
Drug Names	FANAPT, FANAPT TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AURYXIA
Drug Names	AURYXIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage will be denied if request is for an indication excluded from Part D.

Prior Authorization Group	AUSTEDO
Drug Names	AUSTEDO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AVASTIN
Drug Names	AVASTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	AYVAKIT
Drug Names	AYVAKIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	B VS. D
Drug Names	ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN II, AMINOSYN-PF 7%, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINISOL SF 15%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DEPO-PROVERA, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, EVEROLIMUS, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROMORPHONE HYDROCHLORI, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEPHRAMINE, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PENTAMIDINE ISETHIONATE, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVERT, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TAXOTERE, TDVAX, TENIVAC, TOPOSAR, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCRISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	N/A
Other Criteria	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.
Prior Authorization Group	BALVERSA
Drug Names	BALVERSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prior Authorization Group	BANZEL
Drug Names	BANZEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-
Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving standard therapy (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) for SLE OR 2) patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BERINERT
Drug Names	BERINERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): patient has hereditary angioedema with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BETASERON
Drug Names	BETASERON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BEXAROTENE
Drug Names	BEXAROTENE, TARGRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSENTAN
Drug Names	BOSENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
Exclusion Criteria	-
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: 1) Patient received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient has chronic phase CML (includes newly diagnosed) and meets one of the following conditions: a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRAFTOVI
Drug Names	BRAFTOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRIVIACT
Drug Names	BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRUKINSA
Drug Names	BRUKINSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BUPRENORPHINE
Drug Names	BUPRENORPHINE HCL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) The requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CALCIPOTRIENE
Drug Names	CALCIPOTRIENE, CALCITRENE, ENSTILAR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	-
Required Medical Information	For NSCLC: the requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CERDELGA
Drug Names	CERDELGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Type 3 Gaucher disease
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	CHANTIX
Drug Names	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	CLOBAZAM
Drug Names	CLOBAZAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLOMIPRAMINE
Drug Names	CLOMIPRAMINE HCL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Depression, Panic Disorder
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI) , mirtazapine, bupropion
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.

Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell
Exclusion Criteria	-
Required Medical Information	For NSCLC: The requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COPIKTRA
Drug Names	COPIKTRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan year
Other Criteria	-

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from melanoma
Exclusion Criteria	-
Required Medical Information	For melanoma (including brain metastases): 1) The disease is unresectable or metastatic, 2) The disease is positive for the BRAF V600E or V600K mutation, AND 3) The requested medication will be used in combination with vemurafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of corneal cystine crystal accumulation in patients with cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DALFAMPRIDINE
Drug Names	DALFAMPRIDINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple sclerosis new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-