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	Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or contraindication to methotrexate or cyclosporine.

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.
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) (World Health Organization [WHO] Group 1): PAH 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, 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. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.
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 of mucopolysaccharidosis I 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 or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
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 or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AMBRISENTAN
Drug Names	AMBRISENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (PAH) (World Health Organization [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	AMPHETAMINES
Drug Names	AMPHETAMINE/DEXTROAMPHETA
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has the diagnosis of narcolepsy confirmed by a sleep study.
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 patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (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 a non-steroidal anti-inflammatory drug and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient 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	For Cryopyrin-Associated Periodic Syndromes (CAPS): 12 years of age or older.
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: aripiprazole, lurasidone, 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	The requested drug is not being prescribed for treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis

Prior Authorization Group	AUSTEDO - PENDING CMS REVIEW
Drug Names	AUSTEDO
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
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 low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, leptomeningeal metastases and metastatic spine tumors, malignant pleural mesothelioma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, AIDS-related Kaposi sarcoma, uterine cancer, endometrial cancer, vulvar cancer, and ophthalmic-related disorders: 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. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to both Mvasi AND Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

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-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, DEXTROSE 50%, DEXTROSE 70%, 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, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, 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, 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	For patients new to therapy: severe active lupus nephritis, severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid or antimalarial) for SLE OR 2) patient is not currently receiving stable standard therapy regimen for SLE because patient tried and had an inadequate response or intolerance to stable standard therapy regimen.
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 (HAE) 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 an 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, Some Medically-accepted Indications
Off-label Uses	Eisenmenger's syndrome
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [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. For Eisenmenger's syndrome: Patient is diagnosed with Eisenmenger's syndrome, WHO functional class III PAH.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSULIF - PENDING CMS REVIEW
Drug Names	BOSULIF
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
Other Criteria	-

Prior Authorization Group	BRAFTOVI - PENDING CMS REVIEW
Drug Names	BRAFTOVI
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
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
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRIVIACT INJ
Drug Names	BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	16 years of age or older
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 use disorder AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 4) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months
Other Criteria	-

Prior Authorization Group	CABOMETYX - PENDING CMS REVIEW
Drug Names	CABOMETYX
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
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 when the patient's disease expresses rearranged during transfection (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	For Gaucher disease, the diagnosis 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	For Gaucher disease, the diagnosis 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 the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI), 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 the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), 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 a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) 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.
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 benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: 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 when the patient's disease expresses rearranged during transfection (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, Some Medically-accepted Indications
Off-label Uses	Gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, splenic marginal zone lymphoma
Exclusion Criteria	-
Required Medical Information	For follicular lymphoma: the requested drug will be used as second-line or subsequent therapy. For gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma: the requested drug will be used as subsequent therapy after at least 2 prior therapies.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
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	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: Diagnosis of nephropathic cystinosis 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 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, patient must meet the following: For new starts, prior to initiating therapy, patient meets the following: patient demonstrates sustained walking impairment. For continuation of therapy, patient meets the following: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DAURISMO
Drug Names	DAURISMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Post remission therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory disease as a component of repeating the initial successful induction regimen for AML.
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia: 1) the requested medication must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, and 3) the requested medication will be used as treatment for induction therapy, post-remission therapy, or relapsed or refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DEFERASIROX
Drug Names	DEFERASIROX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DEMSER
Drug Names	DEMSER, METYROSINE
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	DESVENLAFAXINE
Drug Names	DESVENLAFAXINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DHE NASAL
Drug Names	DIHYDROERGOTAMINE MESYLAT
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 triptan 5-HT1 receptor agonist
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM
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 a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of spasticity caused by upper motor neuron disorders (e.g., cerebral palsy and paraplegia), athetosis, or stiff-man syndrome OR 4) For use as an adjunct for the relief of skeletal muscle spasms due to reflex spasm to local pathology (e.g., inflammation of the muscles or joints, or secondary to trauma) OR 5) For adjunctive therapy in the treatment of convulsive disorders OR 6) For the short-term relief of the symptoms of anxiety.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Short-term relief anx-1 mo, skeletal muscles spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: 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	DICLOFENAC GEL 1% - PENDING CMS REVIEW
Drug Names	DICLOFENAC SODIUM
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
Other Criteria	-

Prior Authorization Group	DICLOFENAC SOLN - PENDING CMS REVIEW
Drug Names	PENNSAID
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
Other Criteria	-

Prior Authorization Group	DRIZALMA
Drug Names	DRIZALMA SPRINKLE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cancer pain, chemotherapy-induced neuropathic pain
Exclusion Criteria	-
Required Medical Information	The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)
Age Restrictions	Generalized Anxiety Disorder - 7 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EMSAM
Drug Names	EMSAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENBREL
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Severe, refractory hidradenitis suppurativa, graft versus host disease
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only):1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENDARI
Drug Names	ENDARI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	5 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
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	EPO
Drug Names	PROCRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	16 weeks
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 (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin treatment in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, human immunodeficiency virus (HIV), hepatitis C treatment, anemia due to myelosuppressive cancer chemotherapy, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than 12 g/dL.

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult medulloblastoma
Exclusion Criteria	-
Required Medical Information	Adult medulloblastoma: patient has received chemotherapy previously AND has tumor(s) with mutations in the sonic hedgehog pathway
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERLEADA
Drug Names	ERLEADA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For all indications: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERLOTINIB
Drug Names	ERLOTINIB HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent or advanced non-small cell lung cancer (NSCLC), recurrent chordoma, renal cell carcinoma (RCC), brain metastases from NSCLC.
Exclusion Criteria	-
Required Medical Information	For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the member has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ESBRIET
Drug Names	ESBRIET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EVEROLIMUS
Drug Names	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors 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: The disease is relapsed or metastatic. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Fabry disease: diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FARYDAK
Drug Names	FARYDAK
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	FASENRA
Drug Names	FASENRA, FASENRA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma with an eosinophilic phenotype: For initial therapy: 1) Patient has baseline blood eosinophil count of at least 150 cells per microliter, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). For continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FETZIMA
Drug Names	FETZIMA, FETZIMA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FINTEPLA - PENDING CMS REVIEW
Drug Names	FINTEPLA
PA Indication Indicator	-
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	-
Other Criteria	-

Prior Authorization Group	FORTEO
Drug Names	FORTEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Partial-onset seizures: 4 years of age or older, Primary generalized tonic-clonic seizures: 12 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GATTEX
Drug Names	GATTEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short bowel syndrome (SBS) initial therapy: Adult patients were dependent on parenteral support for at least 12 months. Pediatric patients were dependent on nutrition/IV fluids to account for at least 30 percent of caloric and/or fluid/electrolyte needs. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GILENYA
Drug Names	GILENYA
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	GILOTRIF
Drug Names	GILOTRIF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from non-small cell lung cancer.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or 2) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC: Patient has a known sensitizing EGFR mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GLATIRAMER
Drug Names	GLATIRAMER ACETATE, GLATOPA
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	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

Prior Authorization Group	HAEGARDA
Drug Names	HAEGARDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE 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 an antihistamine for at least one month.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	HARVONI
Drug Names	HARVONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	-

Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

Prior Authorization Group	HERCEPTIN HYLECTA
Drug Names	HERCEPTIN HYLECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months, Other: 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	HERZUMA
Drug Names	HERZUMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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. For FDA-approved indications and off-label uses that overlap: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	-