- Actemra intravenous

	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD. Exclude for indication of COVID-19 treatment in hospitalized patients (ie, non-D use). Diagnosis, concurrent medicagnosis, j(72(urpre)-2viousnc)4 drugs tried

- Adempas

- Adstiladrin

	N/A

- Aimovig Autoinjector

	Combination therapy with Ajovy, Vyepti or Emgality
	Diagnosis, number of migraine headaches per month
	18 years and older
	N/A
	1 year
	Approve if the patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication).
	All FDA-approved Indications.
	N/A
	No

- Akeega

- Aldurazyme

	N/A
	Diagnosis, genetic and lab test results
	N/A
	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
	1 year
	Approve if the patient has a laboratory test demonstrating deficient alpha-L-iduronidase activity in leukocytes, fibroblasts, plasma, or serum OR has a molecular genetic test demonstrating alpha-L-iduronidase gene mutation
	All FDA-approved Indications.
	N/A
	No

-

- Alunbrig oral tablet 180 mg, 30 mg, 90 mg
- Alunbrig oral tablets,dose pack

	N/A
	ALK status

	Diagnosis
	N/A
	N/A
	3 months
	N/A
	All FDA-approved Indications.
	N/A
	No

- APOKYN
- apomorphine

	Concurrent use with a serotonin 5-HT3 Antagonist
	Diagnosis, other therapies
	N/A
	Prescribed by or in consultation with a neurologist
	1 year
	Parkinson's disease (PD)-approve if the patient meets the following criteria: 1. patient is experiencing off episodes such as muscle stiffness, slow movements, or difficulty starting movements, 2. Patient is currently receiving carbidopa/levodopa, 3.patient has previously tried one other treatment for off episodes and had significant intolerance or inadequate efficacy.
	All FDA-approved Indications.
	N/A
	No

- Arikayce

	N/A
	Diagnosis, previous medication history (as described in Other Criteria field) MAC-

- teriflunomide

	Concurrent use of teriflunomide with other disease-modifying agents used for multiple sclerosis (MS)
	Relapsing form of MS, to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
	N/A
	Prescribed by or in consultation with a neurologist or MS specialist. Authorization will be for 1 year.

- Augtyro

	N/A
	Diagnosis
	NSCLC - 18 years and older, Solid tumors - 12 years and older
	N/A
	1 year
	Non-Small Cell Lung Cancer-approve if the patient has locally advanced or metastatic disease, patient has ROS1-positive non-small cell lung cancer and the mutation was detected by an approved test. Solid tumors - approve if tumor is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion AND tumor is locally advanced or metastatic or surgical resection will likely result in severe morbidity AND disease has progressed following treatment or there are no satisfactory alternative therapies.
	All FDA-approved Indications.
	N/A
	No

- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit

	Concurrent use of other disease-modifying agent used for multiple sclerosis
	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
	N/A
	Prescribed by or after consultation with a neurologist or an MS specialist.

- Benlysta

	Concurrent Use with Other Biologics or Lupkynis
	Diagnosis, medications that will be used in combination, autoantibody status
	Lupus Nephritis: 18 years and older (initial). SLE: 5 years and older (initial).
	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
	SLE-Initial-4 months, cont-1 year. Lupus Nephritis-6 mo initial, 1 year cont
	Lupus Nephritis Initial-approve if the patient has a diagnosis of lupus nephritis confirmed on biopsy (For example, World Health Organization class III, IV, or V lupus nephritis), AND the medication is being used concurrently with an immunosuppressive regimen (ex: azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil and/or a systemic corticosteroid). Cont-approve if the medication is being used concurrently with an immunosuppressive regimen (ex: azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil and/or a systemic corticosteroid) AND the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA] AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g.,

- Besremi

	Concomitant use with other interferon products
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	N/A
	All FDA-approved Indications.
	N/A
	No

- ibandronate intravenous

Concurrent use with other medications for Osteoporosis

- ambrisentan
- bosentan

	N/A
	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
	N/A
	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH - prescribed by or in consultation with a cardiologist or pulmonologist

Authorization will be for 1 year.

- Bosulif oral capsule 100 mg, 50 mg
- Bosulif oral tablet 100 mg, 400 mg, 500 mg

	N/A

- Braftovi

	N/A
	Diagnosis, BRAF V600 status
	18 years and older
	N/A
	1 year
	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation. Colon or Rectal cancer- approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer. NSCLC- approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Mektovi (binimetinib tablets).
	All FDA-approved Indications.
	N/A
	No

- Brukinsa

	N/A
	Diagnosis, prior therapies
	18 years and older
	N/A
	1 year
	Under CMS Review
	All FDA-approved Indications, Some Medically-accepted Indications.
	Under CMS Review
	No

- Caprelsa oral tablet 100 mg, 300 mg

	N/A
	N/A
	N/A
	N/A

1 year

- Chemet

	N/A
	Blood lead level
	Approve in patients between the age of 12 months and 18 years Prescribed by or in consultation with a professional experienced in the use of chel.83 098.784 0.48 reusetes3 a professional 7 18.84 reW*nBT0 g170.3

- Chenodal

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 1 year

- Cholbam oral capsule 250 mg, 50 mg

	All FDA-approved Indications.
	N/A
	No

- Cimerli

	N/A
	Diagnosis
	N/A
	Administered by or under the supervision of an ophthalmologist
	1 year
	N/A
	All FDA-approved Indications, Some Medically-accepted Indications.
	Retinopathy of prematurity
	No

- Cimzia
- Cimzia Powder for Reconst

	preferred adalimumab product. Note: if the patient does not meet this requirement, a previous trial of another non-preferred adalimumab product will also count. Plaque Psoriasis (PP), initial tx-approve if the patient has tried TWO of the following drugs in the past: Enbrel, a preferred adalimumab product, Skyrizi, Stelara SC, Otezla or Taltz. A trial of multiple preferred adalimumab products counts as ONE preferred product. Cont tx, AS/PsA/RA/CD/PP - approve if the pt had a response as determined by the prescriber. Non-radiographic axial spondylitis (nr-axSpA), initial tx-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroilitis reported on MRI. nr-axSpA continuation tx-approve if the patient has had a response as determined by the prescriber. Please Note: preferred adalimumab products include Humira (NDCs starting with -00074), Cyltezo, Hyrimoz (NDCs starting with -61314), adalimumab-adaz, adalimumab-adbm (NDCs starting with -00597), Simlandi.
	All FDA-approved Indications.
	N/A
	No

	patient has received two or more lines of systemic therapy, the medication will be given as a single agent and the patient has or will receive pretreatment with obinutuzmab intravenous infusion before the first dose of Columvi. Note: Examples of systemic therapy include RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) and RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine).
	All FDA-approved Indications, Some Medically-accepted Indications.

- Cometriq oral capsule 100 mg/day(80 mg x1-20 mg x1), 140 mg/day(80 mg x1-20 mg x3), 60 mg/day (20 mg x 3/day)

	N/A
	Diagnosis.
	18 years and older

- Copiktra

	N/A
	Diagnosis, previous therapies
	18 years and older
	N/A
	1 year
	Chronic Lymphocytic Leukemia/ Small Lymphocytic Lymphoma - approve if the patient has tried one systemic regimen (e.g., Imbruvica (ibrutinib capsules, tablets and oral solution), Venclexta (venetoclax tablets), rituximab, Gazyva (obinutuzumab intravenous infusion), chlorambucil, fludarabine, cyclophosphamide, bendamustine, high-dose methylprednisolone, Campath (alemtuzumab intravenous infusion), Calquence (acalabrutinib capsules), Brukinsa (zanubrutinib capsules), or Arzerra (ofatumumab intravenous infusion). T-cell lymphoma- For peripheral T-cell lymphoma, approve. For breast implant-associated anaplastic large cell lymphoma, or hepatosplenic T-cell lymphoma, approve if the patient has relapsed or refractory disease.
	All FDA-approved Indications, Some Medically-accepted Indications.
	T-cell Lymphoma
	No

- Cotellic

	N/A
	Melanoma initial - must have BRAF V600 mutation.
	18 years and older
	N/A
	1 year
	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf. CNS Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i. Adjuvant treatment of one of the following conditions (a, b, or c): a) Pilocytic astrocytoma OR b) Pleomorphic xanthoastrocytoma OR c) Ganglioglioma OR ii. Recurrent or progressive disease for one of the following conditions (a, b, c or d): a) glioma OR b) isocitrate dehydrogenase-2 (IDH2)-mutant astrocytoma OR c) Glioblastoma or d) Oligodendroglioma OR iii. Melanoma with brain metastases AND medication with be taken in combination with Zelboraf (vemurafenib tablets). Histiocytic Neoplasm-approve if the patient meets one of the following (i, ii, or iii): i. Patient has Langerhans cell histiocytosis and one of the following (a, b, or c): a) Multisystem disease OR b) Pulmonary disease OR c) Central nervous system lesions OR ii. Patient has Erdheim Chester disease OR iii. Patient has Rosai-Dorfman disease.
	All FDA-approved Indications, Some Medically-accepted Indications.

- Cresemba oral

	N/A
	Diagnosis
	N/A
	N/A
	3 months
	N/A

- Cystagon

	Concomitant use of Cystagon and Procysbi
	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
	N/A Prescribed by or in consultation with a nephrologist or a metabolic disease

- dalfampridine

	N/A
	N/A
	18 years and older (initial and continuation therapy)
	MS. If prescribed by, or in consultation with, a neurologist or MS specialist (initial and continuation).
	Initial-4months, Continuation-1 year

Initial-

- Daurismo oral tablet 100 mg, 25 mg

	N/A
	Diagnosis, medications that will be used in combination, comorbidities
	18 years and older

- dimethyl fumarate oral capsule,delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg

	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS). Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-

- Doptelet (10 tab pack)
- Doptelet (15 tab pack)
- Doptelet (30 tab pack)

	N/A

- Dupixent Pen subcutaneous pen injector 200 mg/1.14 mL, 300 mg/2 mL
- Dupixent Syringe subcutaneous syringe 100 mg/0.67 mL, 200 mg/1.14 mL, 300 mg/2 mL

	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody (i.e., Adbry, Cinqair, Fasenra, Nucala, Tezspire, or Xolair). Concurrent use with Janus Kinase Inhibitors (JAKis) [oral or topical].
	Diagnosis, prescriber specialty, other medications tried and length of trials
	AD-6 months and older, asthma-6 years of age and older, Esophagitis-1 yr and older, Chronic Rhinosinusitis/Prurigo nodularis-18 and older
	Atopic Dermatitis/prurigo nodularis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist. Esophagitis-presc/consult-allergist or gastro
	AD-Init-4mo, Cont-1 yr, asthma/Rhinosinusitis/esophagitis/prurigo nod-init-6 mo, cont 1 yr AD, Init

	combo tx w/BOTH of the following (a and b): a)ICS AND b) 1 add asthma controller/maintenance med(NOTE:exception to the requirement for a trial of 1 add asthma controller/maint med can be made if pt already received anti-IL-5 tx or Xolair used concomitantly w/an ICS AND iii.asthma uncontrolled or was uncontrolled prior to starting anti-IL tx or Xolair defined by 1 (a, b, c, d or e): a)exper 2 or more asthma exacer req tx with systemic corticosteroids in previous yr OR b)exper 1 or more asthma exacer requiring hosp or ED/urgent care visit in prev yr OR c)FEV1 less than 80 percent predicted OR d)FEV1/FVC less than 0.80 OR e)asthma worsens w/tapering of oral CS tx.Cont-pt meets (i and ii): i.cont to receive tx with 1 ICS or 1 ICS-containing combo inhaler AND ii.has responded to Dupixent.Chronic rhinosinusitis with nasal polyposis,initial-pt receiving tx with an intranasal CS and experi rhinosinusitis symptoms like nasal obstruction, rhinorrhea, or reduction/loss of smell AND meets 1 of following (a or b): a)received tx w/syst CS w/in prev 2 yrs or has contraindication to systemic CS tx OR b)prior surgery for nasal polyps. Cont-pt cont to receive tx with an intranasal CS and responded to Dupixent. Eosinophilic esophagitis, initial- weighs greater than or equal to 15 kg, has dx of eosinophilic esophagitis confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high

- Elrexfio

- Elzonris

	N/A
	Diagnosis
	2 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.
	All FDA-approved Indications.
	N/A
	No

• Emgality Pen	• EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML

- Enbrel Mini
- Enbrel subcutaneous solution
- Enbrel subcutaneous syringe
- Enbrel SureClick

	Concurrent use with biologic therapy or targeted synthetic DMARD
	Diagnosis, concurrent medications, previous therapies tried.
	PP-4 years and older (initial therapy)
	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. Psoriatic arthritis, prescribed by or in consultation w/ rheumatologist or dermatologist.Plaque psoriasis (PP), prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist.
	Approve through 12/31/24
	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other systemic therapy for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID), biologic or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane,

	oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD-approve. Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD-Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Graft versus host disease (GVHD), Behcet's disease
	No

- Endari

	N/A
	Diagnosis, prescriber specialty
	Greater than or equal to 5 years of age
	Prescribed by, or in consultation with, a physician who specializes in sickle cell disease (e.g., a hematologist)
	Authorization will be for 1 year.
	N/A
	All FDA-approved Indications.

- Entyvio

	Concurrent Use with Other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs) used for an Inflammatory Condition
	N/A
	CD/UC - adults (initial therapy)
	CD/UC initial - Prescribed by or in consultation with a gastroenterologist. (initial therapy)
	CD/UC

	N/A
	No

- Epclusa oral pellets in packet 150-37.5 mg, 200-50 mg
- Epclusa oral tablet 200-50 mg, 400-100 mg

	Combination use with other direct acting antivirals, excluding ribavirin.
	Genotype (including unknown), prescriber specialty, other medications tried or used in combination with requested medication
	3 years or older
	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
	Criteria will be applied consistent with current AASLD/IDSA guidance.

All FDA

	No

- Erleada oral tablet 240 mg, 60 mg

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year

Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be

- everolimus (antineoplastic) oral tablet
- everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg

	N/A
	Breast Cancer-HER2 status, hormone receptor (HR) status.
	All dx except TSC associated SEGA, renal angiomyolipoma or partial onset seizures-18 years and older.
	N/A
	Authorization will be for 1 year
	Breast Cancer-approve if pt meets ALL the following (A, B, C, D, E, and F):A)pt has recurrent or metastatic,HR+ disease AND B)pt has HER2-negative breast cancer AND C)pt has tried at least 1 prior endocrine therapy AND D)pt meets 1 of the following conditions (i or ii):i.pt is a postmenopausal woman or man OR ii.pt is pre/perimenopausal woman AND is receiving ovarian suppression/ablation with a GnRH agonist, or has had surgical bilateral oophorectomy or ovarian irradiation AND E)pt meets 1 of the following conditions (i or ii): i.Afinitor will be used in combo with exemestane and pt meets 1 of the following:pt is male and is receiving a GnRH analog or pt is a woman or ii. Afinitor will be used in combo with fulvestrant or tamoxifen AND F)pt has not had disease progression while on Afinitor. RCC, relapsed or Stage IV disease-approve if using for non-clear cell disease or if using for clear cell disease, pt has tried 1 prior systemic therapy (e.g., Inlyta, Votrient, Sutent, Cabometyx, Nexavar).TSC Associated SEGA-approve if pt requires therapeutic intervention but cannot be curatively resected. Thymomas and Thymic Carcinomas-approve if pt has tried chemotherapy or cannot tolerate chemotherapy.TSC associated renal angiomyolipoma -approve. WM/LPL -approve if pt has progressive or relapsed disease or if pt has not responded to primary therapy. Thyroid Carcinoma, differentiated-approve if pt is

	refractory to radioactive iodine therapy. Endometrial Carcinoma-approve if Afinitor will be used in combo with letrozole. GIST-approve if pt has tried 2 of the following drugs: Sutent, Sprycel, Stivarga, Ayvakit, Qinlock or imatinib AND there is confirmation that Afinitor will be used in combo with 1 of these drugs (Sutent, Stivarga, or imatinib) in the treatment of GIST. TSC-associated partial-onset seizures-approve. NET tumors of the pancreas, GI Tract, Lung and Thymus (carcinoid tumors)-approve. Soft tissue sarcoma-approve if pt has perivascular epithloid cell tumors (PE Coma) or recurrent angiomyolipoma/lymphangioleiomyomatosis. Classic hodgkin lymphoma-approve if pt has relapsed or refractory disease. Histiocytic neoplasm-approve if pt has Erdheim-Chester disease or, Rosai-Dorfman disease or Langerhans cell histiocytosis. Patient must also have PIK3CA mutation. Meningioma- approve if pt has recurrent or progressive disease AND pt has surgically inaccessible disease and radiation therapy is not possible AND medication will be used in combination with a somatostatin analogue. Uterine Sarcoma-approve if the patient has advanced, recurrent, metastatic, or inoperable disease, AND has a perivascular epithelioid cell tumor (PEComa), AND has tried at least one systemic regimen. Note: Examples of systemic regimen include doxorubicin, docetaxel, gemcitabine, ifosfamide, dacarbazine. All FDA-approved Indications, Some Medically-

- Eylea

	N/A
	Diagnosis
	N/A

- Fabrazyme

	N/A
	Diagnosis, genetic and lab test results
	N/A
	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
	1 year
	Approve if the patient has a laboratory test demonstrating deficient alpha-galactosidase A activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating mutations in the galactosidase alpha gene.
	All FDA-approved Indications.
	N/A
	No

- Fasenra Pen
- Fasenra subcutaneous syringe 10 mg/0.5 mL, 30 mg/mL

	Concurrent use with another monoclonal antibody therapy.
	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
	6 years of age and older
	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
	Authorization will be for 6 months initial, 12 months continuation.
	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with Fasenra or another monoclonal antibody therapy that may lower blood eosinophil levels AND meet both of the following criteria: 1) Patient has received combination therapy with an inhaled corticosteroid AND at least one additional asthma controller or asthma maintenance medication (Examples: LABA, LAMA, leukotrienes, monoclonal antibodies for asthma) AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to receiving Fasenra or another monoclnal antibody therapy for asthma as defined by ONE of the following: a) patient experienced one or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization, an urgent care visit or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation - The patient has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician

	visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid.
	All FDA-approved Indications.
	N/A
	No

- fingolimod

	Concurrent use of fingolimod with other disease-modifying agents used for multiple sclerosis (MS).
	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
	10 years and older
	Prescribed by, or in consultation with, a neurologist or an MS specialist.
	Authorization will be for 1 year.
	N/A
	All FDA-approved Indications.
	N/A
	No

- Firmagon kit w diluent syringe

	N/A
	Diagnosis
	N/A

- Fruzaqla oral capsule 1 mg, 5 mg

	N/A
	Diagnosis
	18 years of age and older
	N/A
	1 year

Colon cancer, rectal cancer, or appendiceal cancer-Approve if the patient meets the following (A and B): A.Patient has advanced or metastatic disease, AND B.Patient has previously been treated with the following (i, ii, and iii): i.Fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, Note: Examples of fluoropyrimidine agents include 5-fluorouracil (5-FU) and capecitabine. AND ii.An anti-vascular endothelial growth factor (VEGF) agent, Note: Examples of anti-VEGF agents include

	No

- Gattex 30-Vial
- Gattex One-Vial

- Gavreto

	N/A
	Diagnosis
	NSCLC-18 years and older, thyroid cancer-12 years and older
	N/A
	1 year
	NSCLC-approve if the patient has metastatic disease and rearranged during transfection (RET) fusion-positive disease detected by an Food and Drug Administration (FDA) approved test. Thyroid cancer-approve if the patient has rearranged during transfection (RET) fusion-positive disease or RET-mutation positive disease and has anaplastic thyroid cancer or the patient has medullary thyroid cancer or the disease is radioactive iodine-refractory.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Medullary Thyroid Cancer
	No

- Gilotrif

	N/A
	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type
	18 years and older
	N/A
	Authorization will be for 1 year
	NSCLC EGFR pos - For the treatment of advanced or metastatic non small cell lung cancer (NSCLC)-approve if the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: examples of sensitizing EGFR mutation-positive NSCLC include the following mutations : exon 19 deletions, exon 21 (L858RP22iation

- glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL
- Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL

- Bydureon BCise
- Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL
- Mounjaro
- Ozempic subcutaneous pen injector 0.25 mg or 0.5 mg (2 mg/3 mL), 1 mg/dose (4 mg/3 mL), 2 mg/dose (8 mg/3 mL)
- Rybelsus
- Trulicity

	N/A
	Diagnosis
	N/A
	N/A
	Authorization will be for 1 year
	N/A
	All FDA-approved Indications.
	N/A
	No

- Zoladex

	N/A
	Diagnosis
	Endometriosis-18 years and older
	Prostate cancer/Breast cancer/Head and Neck/Ovarian/Uterine-prescribed by or in consultation with an oncologist. Endometriosis/abnormal uterine bleeding-prescribed by or in consultation with an obstetrician-gynecologist or a health care practitioner who specializes in the treatment of women's health.
	Abnormal uterine bleeding-2 months, Endometriosis-6 months, all other dx-1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Abnormal uterine bleeding-Zoladex 3.6mg is used as an endometrial-thinning agent prior to endometrial ablation.Endometriosis-approve Zoladex 3.6 mg. Prostate cancer-approve Zoladex 3.6 mg and/or 10.8 mg. Head and Neck Cancer - Salivary Gland Tumors: approve if patient has recurrent, unresectable, or metastatic disease AND has androgen receptor-positive disease.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Zoladex 3.6mg only: head and neck cancer - salivary gland tumors, Ovarian Cancer including Fallopian Tube Cancer and Primary Peritoneal Cancer, and Uterine Cancer
	No

- Eligard
- Eligard (3 month)
- Eligard (4 month)
- Eligard (6 month)
- leuprolide subcutaneous kit
- Lupron Depot

	N/A
	N/A
	Premenstrual disorders - 18 years and older

- gabapentin oral tablet extended release 24 hr 300 mg, 600 mg
- Gralise oral tablet extended release 24 hr 300 mg, 450 mg, 600 mg, 750 mg, 900 mg

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 12 months.
	N/A
	All Medically-accepted Indications.
	N/A
	No

	hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy.Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.
	All FDA-approved Indications, Some Medically-accepted Indications.
	CKD, SHOX, SBS

- benztropine oral

	N/A
	N/A
	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
	N/A
	12 months

- cyclobenzaprine oral tablet 10 mg, 5 mg

	N/A
	N/A
	Patients aged less than 65 years, approve.
	N/A
	Authorization will be for 12 months.
	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
	All Medically-accepted Indications.
	N/A
	No

- diphenhydramine HCl oral elixir
- hydroxyzine HCl oral tablet
- promethazine oral

	N/A
	N/A
	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
	N/A
	Authorization will be for 12 months.
	For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
	All Medically-accepted Indications.
	N/A
	No

	No

- Humira (ONLY NDCS STARTING WITH 00074) subcutaneous syringe kit 40 mg/0.8 mL
- Humira Pen (ONLY NDCS STARTING WITH 00074)
- Humira(CF) (ONLY NDCS STARTING WITH 00074) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL
- Humira(CF) Pen (ONLY NDCS STARTING WITH 00074) subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL
- Humira(CF) Pen Crohns-UC-HS (ONLY NDCS STARTING WITH 00074)
- Humira(CF) Pen Pediatric UC (ONLY NDCS STARTING WITH 00074)
- Humira(CF) Pen Psor-Uv-Adol HS (ONLY NDCS STARTING WITH 00074)

	Concurrent use with another biologic DMARD or targeted synthetic DMARD. Diagnosis, concurrent m1C165.05.

	leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-

- Ibrance

	Liposarcoma
	No

- icatibant
- Sajazir

	N/A
	N/A

- Iclusig

	N/A
	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
	18 years and older
	N/A
	Authorization will be for 1 year
	Patients new to therapy with Acute lymphoblastic leukemia, Philadelphia chromosome positive or chronic myeloid leukemia-approve if the patient has tried Sprycel and had an inadequate response or significant intolerance or have a contraindication or are not a candidate for Sprycel. GIST - approve if the patient tried all of the FDA-approved therapies first to align with NCCN recommendations which include: Imatinib or Ayvakit (avapritinib tablets), AND Sunitinib or Sprycel (dasatinib tablets), AND Stivarga (regorafenib tablets), AND Qinlock (ripretinib tablets). Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if the tumor has ABL1 rearrangement or FGFR1 rearrangement.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia
	No

- Idhifa

	N/A
	IDH2-mutation status
	18 years and older
	N/A
	Authorization will be for 1 year
	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
	All FDA-approved Indications.
	N/A
	No

- imatinib oral tablet 100 mg, 400 mg

	N/A
	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
	ASM, DFSP, HES, MDS/MPD/Myeloid/Lymphoid Neoplasms-18 years and older
	N/A
	1 year
	For ALL/CML, must have Ph-positive for approval of imatinib.Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)-patient has tried Turalio or according to the prescriber, the patient cannot take Turalio. Myelodysplastic/myeloproliferative disease-approve if the condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.Graft versus host disease, chronic-approve if the patient has tried at least one conventional systemic treatment (e.g., imbruvica). Metastatic melanoma-approve if the patient has c-Kit-positive advanced/recurrent or metastatic melanoma. Myeloid/lymphoid neoplasms with eosinophilia-approve if the tumor has an ABL1 rearrangement or an FIP1L1-PDGFRA or PDGFRB rearrangement.
	All FDA-approved Indications, Some Medically-accepted Indications. Chordoma, advanced, aggressive or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma,

H8452_OH-MYC-M-

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral suspension
- Imbruvica oral tablet 140 mg, 280 mg, 420 mg

	N/A
	Diagnosis
	GVHD-1 year and older, other-18 years and older
	N/A
	1 year

CLL- Approve. GVHD-Approve if the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], imatinib, low-dose methotrexate, sirolimus, mycophenolate mofetil, Jakafi [ruxolitinib tablets]). Mantle Cell Lymphoma - approve if the patient has tried one systemic regimen or is not a candidate for a systemic regimen (e.g., bendamustine, rituximab,

- Imjudo

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	HCC, Esophageal/Esophagogastric Junction Ca, Gastric Ca-30 days, NSCLC-6 months

	positive, OR (2) NTRK1/2/3 gene fusion positive, OR (3) MET exon 14 skipping mutation positive, OR (4) RET rearrangement positive, AND b) Imjudo is used as first-line or subsequent therapy, OR iv. Patient meets ALL of the following (a, b, and c): a) The tumor is positive for ONE of the following [(1), (2), (3), or (4)]: (1) EGFR exon 19 deletion or exon 21 L858R mutation positive, OR (2) EGFR S768I, L861Q, and/or G719X

- Ingrezza
- Ingrezza Initiation Pk(tardiv)
- Ingrezza Sprinkle

	N/A
	Diagnosis
	18 years and older
	TD - Prescribed by or in consultation with a neurologist or psychiatrist. Chorea HD - prescribed by or in consultation with a neurologist
	1 year
	Chorea associated with Huntington's Disease- approve if diagnosis is confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36).
	All FDA-approved Indications.
	N/A
	No

- testosterone cypionate
- testosterone enanthate

	N/A
	Diagnosis, lab results
	Delayed puberty or induction of puberty in males-14 years and older
	Gender-Dysphoric/Gender-Incongruent Persons, Persons Undergoing Female-to-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization)-prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients.
	Delayed puberty or induction of puberty in males-6 months, all others-12 months Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decrease-(pr)6(e)TQq163.46 reW*nBT0 g170.33od,

	Persons, Persons Undergoing Female-to-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization)-approve.Note: For a patient who has undergone gender reassignment, use this FTM criterion for hypogonadism indication.

- Inlyta oral tablet 1 mg, 5 mg

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 1 year
	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy. Soft tissue sarcoma-approve if the patient has alveolar soft part sarcoma and the medication will be used in combination with Keytruda (pembrolizumab).
	All FDA-approved Indications, Some Medically-accepted Indications.
	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma, Soft tissue sarcoma
	No

- Inpefa oral tablet 200 mg, 400 mg

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Heart Failure, to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit-approve. Type 2 Diabetes, to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit-approve if the patient has chronic kidney disease AND has one or more cardiovascular risk factor(s).Note: Patients with heart failure should be reviewed under criteria for Heart Failure.

- Inrebic

- gefitinib

	N/A
	N/A
	18 years and older
	N/A
	1 year
	NSCLC-approve if the patient has advanced or metastatic disease and the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I.
	All FDA-approved Indications.
	N/A
	No

- ivermectin oral

- Privigen

	N/A
	N/A
	N/A

- Iwilfin

- Jakafi

	N/A
	N/A
	ALL-less than 21 years of age, GVHD-12 and older, MF/PV/CMML-2/essential thrombo/myeloid/lymphoid neoplasm/T-cell Lymphoma-18 and older
	N/A
	1 year

	Acute lymphoblastic leukemia, atypical chronic myeloid leukemia, chronic monomyelocytic leukemia-2 (CMML-2), essential thrombocythemia, myeloid/lymphoid neoplasms, T-Cell lymphoma
	No

	at least one chemotherapy regimen or is not a candidate for a chemotherapy regimen. Marginal Zone Lymphoma - approve if pt has tried at least one Bruton tyrosine kinase inhibitor.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Richter's Transformation to Diffuse Large B-Cell Lymphoma, Marginal Zone Lymphoma
	No

- Jemperli

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Endometrial cancer-approve if the patient has recurrent, advanced or metastatic disease. Mismatch repair deficient (dMMR) or microsatellite instability high (MSI-H) Solid tumors-approve if the patient has progressed on or after prior treatment and according to the prescriber, the patient does not have any satisfactory alternative treatment options. Small Bowel Adenocarcioma-approve if the patient has dMMR or MSI-H disease or DNA polymerase epsilon/delta (POLE/POLD1) mutation and has advanced or metastatic disease and Jemperli will be used as initial therapy when the patient has received adjuvant oxaliplatin or has a contraindication to oxaliplatin OR Jemperli is used as subsequent therapy and the patient has NOT received oxaliplatin in the adjuvant setting and the patient does NOT have a contraindication to oxaliplatin. Colon, Rectal, or Appendiceal Cancer- approve if patient has mismatch repair deficient (dMMR) or microsatellite instability-high (MSI-H) disease or DNA polymerase epsilon/delta (POLE/POLD1) mutation AND has advanced or metastatic disease AND is being used for neoadjuvant therapy or primary or subsequent therapy.
	All FDA-approved Indications, Some Medically-accepted Indications.

	Small Bowel Adenocarcinoma, Colon, Rectal or Appendiceal Cancer
	No

	experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.
	All FDA-approved Indications.
	N/A
	No

- Kanuma

- Kerendia

	Concomitant use with spironolactone or eplerenone
	Diagnosis
	18 years and older (initial and continuation therapy)
	N/A
	1 year

Diabetic kidney disease-initial-approve if the patient meets the following criteria (i, ii and iii)i. Patient has a diagnosis of type 2 diabetes AND ii. Patient meets one of the following (a or b): a) Patient is currently receiving a maximally tolerated labeled dosage of an angiot8.15 0.12

	No

- Kesimpta Pen

	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
	18 years and older Prescribed by or in consultation with a neurologist or a physician who

- Keytruda

	N/A
	Diagnosis
	Melanoma - 12 and older, Glioma - less than 18 years, all others- 18 and older (except Merkel cell, MSI-H/dMMR tumors, large B-cell lymph, TMB-H)
	Prescribed by or in consultation with an oncologist.
	Adjuvant treatment of melanoma/RCC-approve up to 1 year total, all other dx-1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.
	All FDA-approved Indications, Some Medically-accepted Indications.
	adrenal gland tumor, anal carcinoma, extranodal NK/T-Cell Lymphoma, nasal type, Gestational trophoblastic neoplasia, mycosis fungoides/Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, small cell lung cancer, soft tissue sarcoma, squamous cell skin cancer, thymic carcinoma, vulvar cancer, glioma, Kaposi sarcoma, ovarian/fallopian tube/peritoneal cancer, small bowel adenocarcinoma, thyroid carcinoma, vaginal cancer
	No

- Kimmtrak

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Uveal melanoma-approve if the patient has unresectable or metastatic disease and if the tumor is HLA-A*02:01 positive.
	All FDA-approved Indications.
	N/A
	No

	letrozole. Endometrial cancer - approve if pt meets all of (A, B and C): A) pt has recurrent or metastatic disease, and B) has estrogen receptor (ER)-positive tumors, and C) if request is for Kisqali (not Co-Pack), Kisqali will be used in combination with letrozole.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Pre/peri-menopausal women with breast cancer in combination with fulvestrant, and endometrial cancer
	No

	Circumscribed Glioma, Langerhans Cell Histiocytosis
	No

- Krazati

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Non-

- lapatinib

	N/A
	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
	18 years and older
	N/A

	Bone cancer-chordoma, colon or rectal cancer, breast cancer in pre/peri-menopausal women and men
	Yes

- lenalidomide
- Revlimid

	N/A
	Diagnosis and previous therapies or drug regimens tried.
	18 years and older (except Kaposi's Sarcoma, Castleman's Disease, CNS Lymphoma)
	N/A
	Authorization will be for 1 year
	Follicular lymphoma-approve if the patient is using lenalidomide in combination with rituximab or has tried at least one prior therapy. MCL-approve -if the patient is using lenalidomide in combination with rituximab or has tried at least two other therapies or therapeutic regimens. MZL-approve if the patient is using lenalidomide in combination with rituximab or has tried at least one other therapy or therapeutic regimen. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). B-cell-lymphoma (other)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve. CNS lymphoma-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient has tried at least three other regimens. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed

	or refractory disease. Systemic light chain amyloidosis-approve if lenalidomide is used in combination with dexamethasone. Histiocytic neoplasms-approve if the patient has Langerhans cell histiocytosis with single-system multifocal skin disease or Rosai-Dorfman disease.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis. Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system Lymphoma, Kaposi's sarcoma, histiocytic neoplasms.

	medication will be used in combination with Keytruda (pembrolizumab intravenous injection) AND the patient has disease progression on anti-programmed death receptor-1 (PD-1)/programmed death-ligand 1 (PD-L1)-based therapy. Anaplastic thyroid carcinoma-approve if the medication is used in combination with Keytruda (pembrolizumab intravenous infusion).
	All FDA-approved Indications, Some Medically-accepted Indications.
	Under CMS Review
	No

- Leukine injection recon soln

	N/A
	Diagnosis
	N/A AML if prescribed by or in consultation with an oncologist or hematologist, PBPC/BMT - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation, Radiation syndrome-prescribed by or in consultation with phys 39607.09 Tc

- Belbuca
- buprenorphine transdermal patch
- hydromorphone oral tablet extended release 24 hr
- Methadone Intensol

	the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

- Loqtorzi

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.Nasopharyngeal carcinoma- approve if the patient has recurrent, unresectable, oligometastatic, or metastatic disease AND the patient meets ONE of the following (i or ii): i. Patient meets BOTH of the following (a and b): a) Loqtorzi is used for first-line treatment AND b) Loqtorzi is used in combination with cisplatin and gemcitabine, OR ii. Patient meets both of the following (a and b): a) Loqtorzi is used for subsequent treatment AND b) Loqtorzi is used as a single agent.
	All FDA-approved Indications.
	N/A
	No

- Lorbrena oral tablet 100 mg, 25 mg

	N/A
	Diagnosis, ALK status, ROS1 status, previous therapies
	18 years and older
	N/A
	1 year
	Erdheim Chester disease-approve if the patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory myofibroblastic tumor (IMT)-approve if the patient has IMT with ALK translocation. NSCLC - Approve if the patient has ALK-positive advanced or metastatic NSCLC, as detected by an approved test. In addition, patients new to therapy must also have a trial of Alecensa prior to approval of Lorbrena. NSCLC-ROS1 Rearrangement-Positive, advanced or metastatic NSCLC-approve if the patient has tried at least one of crizotinib, entrectinib or ceritinib.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Non-small cell lung cancer (NSCLC)-ROS1 Rearrangement-Positive, Erdheim Chester Disease, Inflammatory Myofibroblastic Tumor (IMT)
	No

- Lumizyme

	N/A
	Diagnosis, genetic and lab test results
	N/A
	Prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
	1 year Approve if the patient has a laboratory test demonstrating deficient acid alpha

- Lunsumio

- Lupron Depot

	N/A
	N/A
	Premenstrual disorders - 18 years and older
	Prostate cancer-prescr/consult with oncologist or urologist. For the treatment of other cancer diagnosis must be prescribed by or in consultation with an oncologist.
	uterine leiomyomata 3 mo.All other=12 mo
	For a diganosis of prostate cancer, patients are required to try Orgovyx or Eligard prior to approval. Premenstrual disorders including PMS and PMDD- approve if pt has severe refractory premenstrual symptoms AND pt has tried an SSRI or combined oral contraceptive.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Ovarian cancer including fallopian tube and primary peritoneal cancer, breast cancer, prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors, premenstrual disorders including premenstrual syndrome and premenstrual dysphoric disorder, uterine cancer
	No

- Lynparza

	N/A
	N/A
	18 years and older
	N/A
	1 year

Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if the patient meets one of the following criteria (A or B): A) The patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. The patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclipy regimen (e.g., carbo T

	cancer. Pancreatic Cancer-maintenance therapy-

- Lytgobi oral tablet 12 mg/day (4 mg x 3), 16 mg/day (4 mg x 4), 20 mg/day (4 mg x 5)

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease, tumor has fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements as detected by an approved test and if the patient has been previously treated with at least one systemic regimen. Note: Examples of systemic regimens include gemcitabine + cisplatin, 5-fluorouracil + oxaliplatin or cisplatin, capecitabine + cisplatin or oxaliplatin, gemcitabine + Abraxane (albumin-bound paclitaxel) or capecitabine or oxaliplatin, and gemcitabine + cisplatin + Abraxane.
	All FDA-approved Indications.
	N/A
	No

- Mekinist oral recon soln
- Mekinist oral tablet 0.5 mg, 2 mg

	N/A
	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
	1 year and older

- Mektovi

	N/A
	Diagnosis, BRAF V600 status, concomitant medications
	18 years and older
	N/A
	1 year
	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi. Histiocytic neoplasm-approve if the patient has Langerhans cell histiocytosis and one of the following (i, ii, or iii): i. multisystem disease OR, ii. pulmonary disease or, iii. central nervous system lesions. NSCLC-approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Braftovi (encorafenib capsules).
	All FDA-approved Indications, Some Medically-accepted Indications.

Hist

- memantine oral capsule,sprinkle,ER 24hr
- memantine oral solution
- memantine oral tablet
- Namzaric

- Mepsevii

- Myfembree

	N/A
	Diagnosis, test results
	18 years and older
	Fibroids-Prescribed by or in consultation with an obstetrician-gynecologist or a health care practitioner who specializes in the treatment of women's health
	24 months of total therapy between Myfembree or Oriahnn
	Uterine Fibroids (Leiomyomas)-approve if the patient is premenopausal (before menopause) and is experiencing heavy menstrual bleeding associated with the uterine fibroids, the uterine fibroids have been confirmed by a pelvic ultrasound, including transvaginal ultrasonography or sonohysterography, hysteroscopy, or magnetic resonance imaging. Endometriosis-approve if the patient is premenopausal and patient has previously tried one of the following (i or ii): i. A contraceptive (e.g., combination oral contraceptives, levnorgestrel-releasing intrauterine systems, a depo-medroxyprogesterone injection), unless contraindicated OR ii. An oral progesterone (e.g., norethindrone tablets), unless contraindicated.Note: An exception to this requirement can be made if the patient has previously used a gonadotropin-releasing hormone agonist (e.g., Lupron Depot [leuprolide depot suspenion]) or Orilissa (elagolix tablets).
	All FDA-approved Indications.
	N/A
	No

- Naglazyme

	N/A
	Diagnosis, genetic and lab test results
	N/A
	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
	1 year
	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating arylsulfatase B gene mutation.
	All FDA-approved Indications.
	N/A
	No

- Nayzilam

	N/A
	Diagnosis, other medications used at the same time
	N/A
	Prescribed by or in consultation with a neurologist
	1 year
	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
	All FDA-approved Indications.
	N/A
	No

- Nerlynx

	N/A

- Nexletol

	N/A
	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field) 18 years and older

	of the following: Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina (stable or unstable), history of stroke or TIA, CAD, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly and LDL-C remains greater than or equal to 55 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. PRIMARY HYPERLIPIDEMIA (not associated with ASCVD or HeFH) [A or B]: A) tried one high-intensity statin (defined above) and ezetimibe for 8 weeks or longer and LDL-C remains 70 mg/dL or higher or B) statin intolerant (defined above).
	All FDA-approved Indications.
	N/A
	No

	conditions: prior MI, history of ACS, diagnosis of angina (stable or unstable), history of stroke or TIA, CAD, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL-C remains greater than or equal to 55 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. PRIMARY HYPERLIPIDEMIA (not associated with ASCVD or HeFH) [A or B]: A) tried one high-intensity statin (defined above) for 8 weeks or longer and LDL-C remains 70 mg/dL or higher or B) statin intolerant (defined above).
	All FDA-approved Indications.
	N/A
	No

- nilutamide

- nitisinone

	Concomitant therapy with nitisinone products
	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)

N/A

305.T DEEMA7e-305 TMOBT427e-74307.85*BT0320BT307.85*n07 18.84 reW* 0.48 ref*165.05 479.3324 59898.78re

- Nivestym

	N/A

	[absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

	an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.] Gender-Dysphoric/Gender-Incongruent Persons, Persons Undergoing Female

	physician AND Pt cont to receive tx with an inhaled corticosteroid. EGPA initial-approve if pt has active, non-severe disease, has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to any monoclonal antibody that may lower blood eosinophil levels. Cont-pt responded to Nucala tx as determined by the prescribing physician.HES initial-pt has had hypereosinophilic synd for greater than or equal to 6 months AND has FIP1L1-PDGFRalpha-negative dis AND pt does NOT have identifiable non-hematologic secondary cause of hypereosinophilic synd AND prior to initiating tx with monoclonal antibody that may lower blood eosinophil levels, pt has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter. Cont-approve if the patient has responded to Nucala tx. Nasal polyps, initial-approve if pt meets ALL of the following criteria(A, B, C and D):A) pt has chronic rhinosinusitis w/nasal polyposis as evidenced by direct examination, endoscopy, or sinus CT scan AND B)pt experienced 2 or more of the following sympt for at least 6 months:nasal congest/obstruct/discharge, and/or reduction/loss of smell AND C)pt meets BOTH of the following (a and b): a)Pt has received tx with intranasal corticosteroid AND b)Pt will continue to receive tx with intranasal corticosteroid concomitantly with Nucala AND D)pt meets 1 of the following (a, b or c): a)Pt has received at least 1 course of tx with a systemic corticosteroid for 5 days or more within the previous 2 years, OR b)Pt has a contraindication to systemic corticosteroid tx, OR c)Pt had prior surgery for nasal polyps.Cont-approve if the pt has received at least 6 months of therapy, continues to receive tx with an intranasal corticosteroid and has responded to tx.

- Nuedexta

	N/A
	N/A
	N/A
	N/A
	1 year
	N/A
	All FDA-approved Indications.
	N/A
	No

- Nuplazid

	N/A

- Nurtec ODT

- Nyvepria

	No

- Ocaliva

- octreotide acetate

	N/A
	Diagnosis
	N/A
	Acromegaly-prescr/consult w/endocrinologist. NETs-prescr/consult w/oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescr/consult w/endo/onc/neuro.Meningioma-prescr/consult w/oncologist, radiologist, neurosurg/thymoma/thymic carcinoma-presc/consult with oncologist
	1 year
	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. Patient has had an inadequate response to surgery and/or radiotherapy OR ii. Patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. Patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND Patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Meningioma, thymoma and thymic carcinoma, pheochromocytoma and paraganglioma
	No

- Odomzo

	N/A
	BCC - Must not have had disease progression while on Erivedge (vismodegib).
	18 years and older
	N/A
	1 year
	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve, if the disease is limited to nodal metastases. (Note-This includes primary or recurrent nodal metastases. A patient with distant metastasis does not meet this requirement.)
	All FDA-approved Indications, Some Medically-accepted Indications.
	Metastatic BCC
	No

- Ofev

	N/A
	N/A
	18 years of age and older
	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
	1 year
	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45 percent of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10 percent of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
	All FDA-approved Indications.
	N/A
	No

- Ojemda oral suspension for reconstitution
- Ojemda oral tablet 400 mg/week (100 mg x 4), 500 mg/week (100 mg x 5), 600 mg/week (100 mg x 6)

	N/A
	Diagnosis
	6 months of age and older
	N/A

-

- Opdivo

	N/A
	Diagnosis
	colon/rectal-12 years and older, pediatric hodgkin lymphoma-less than 18 years old, All other (except gestational trophoblastic)-18 years and older
	Prescribed by or in consultation with an oncologist.
	Adjuvant treatment of melanoma-approve up to 1 year total, all other dx-1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.
	All FDA-approved Indications, Some Medically-accepted Indications.
	anal carcinoma, cervical carcinoma, endometrial carcinoma, extranodal NK/T-Cell Lymphoma, gestational trophoblastic neoplasia, merkel cell carcinoma, neuroendocrine tumors, pediatric hodgkin lymphoma, small bowel adenocarcinoma, small cell lung cancer, vulvar cancer, ampullary adenocarcinoma, bone cancer, diffuse high-grade gliomas, Kaposi sarcoma, primary mediastinal large B-cell lymphoma, biliary tract cancers, soft tissue sarcoma
	No

- Opdualag

	N/A
	Diagnosis
	12 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B vs Part D determination will be made at time of prior authorization review per CMS guidance. Melanoma-approve if the patient is greater than or equal to 40 kg and either (i or ii): (i) the patient has unresectable or metastatic disease or (ii) medication is used as neoadjuvant therapy.
	All FDA-approved Indications.
	N/A
	No

- Opsumit

	N/A
	PAH WHO group, right heart catheterization results
	N/A
	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
	Authorization will be for 1 year
	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
	All FDA-approved Indications.
	N/A
	No

- Orencia (with maltose)
- Orencia ClickJect
- Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
	Diagnosis, concurrent medications, previous drugs tried.
	N/A
	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
	Approve through 12/31/24
	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). PsA, initial -approve. Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], initial - approve if the patient has tried one other agent for this condition or the patient will be starting on Orencia concurrently with methotrexate, sulfasalazine or leflunomide or the patient has an absolute contraindication to methotrexate, sulfasalazine or leflunomide or the patient has aggressive disease as determined by the prescribing physician. Cont tx - responded to therapy as per the prescriber.
	All FDA-approved Indications.
	N/A
	No

- Orserdu oral tablet 345 mg, 86 mg

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Breast cancer in postmenopausal women or Men-approve if the patient meets the following criteria (A, B, C, D, and E): A) Patient has recurrent or metastatic disease, AND B) Patient has estrogen receptor positive (ER+) disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative disease, AND D) Patient has not received prior treatment with an oral selective estrogen receptor degrader (SERD), AND E) Patient has not received prior treatment with an oral estrogen receptor antagonist

- Padcev

	N/A
	Diagnosis, prior therapies
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Urothelial carcinoma-approve if the patient has locally advanced or metastatic disease and meets either (i or ii): (i): Padcev is used as first-line therapy and will be used in combination with Keytruda (pembrolizumab intravenous infusion), or (ii): Padcev is used as subsequent therapy.
	All FDA-approved Indications.
	N/A

- Pemazyre

	N/A
	Diagnosis, prior therapies
	18 years and older
	N/A
	Authorization will be for 1 year
	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease and the tumor has a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen. Myeloid/lymphoid neoplasms-approve if the patient has eosinophilia and the cancer has fibroblast growth factor receptor 1 (FGFR1) rearrangement, as detected by an approved test and the cancer is in chronic phase or blast phase. All FDA-approved Indications.

- penicillamine oral tablet

	N/A
	Diagnosis
	N/A
	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
	1 year

Cystinuria-approve. Wilson's disease-approve if diagnosis is confirmed by ONE of the following (i or ii): i. Genetic testing results confirming biallelic pathogenic ATP7B mutations (in either symptomatic or asymptomatic individuals), OR ii. Confirmation of at least two of the following (a, b, c, d): a) Presence of Kayser-Fleischer rings, b) Serum ceruloplasmin level less than 20 mg,) Presenc) Preseayser

- metyrosine

	N/A
	Diagnosis, prior medication trials
	N/A
	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for metyrosine)
	Authorization will be for 1 year
	If the requested drug is metyrosine for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
	All FDA-approved Indications.
	N/A
	No

- Alyq
- sildenafil (Pulmonary Arterial Hypertension) intravenous solution 10 mg/12.5 mL
- sildenafil (Pulmonary Arterial Hypertension) oral tablet 20 mg
- tadalafil (pulmonary arterial hypertension) oral tablet 20 mg

	Concurrent Use With Guanylate Cyclase Stimulators.
	Diagnosis, right heart cath results
	N/A
	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
	Authorization will be for 1 year.
	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
	All FDA-approved Indications.
	N/A
	No

- Piqray

	N/A
	Diagnosis, prior therapies
	N/A
	N/A
	1 year

Breast

- pirfenidone oral capsule
- pirfenidone oral tablet 267 mg, 801 mg

	N/A
	N/A
	18 years of age and older Prescribed by or in consultation with a pulmonologist

- Plegridy intramuscular
- Plegridy subcutaneous pen injector 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL
- Plegridy subcutaneous syringe 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL

- Polivy

	N/A
	Diagnosis, prior therapies

- Pomalyst

- posaconazole oral tablet,delayed release (DR/EC)

	N/A

- Prevymis intravenous
- Prevymis oral

	N/A
	Diagnosis
	N/A
	N/A
	6 months
	N/A
	All FDA-approved Indications.
	N/A
	No

- Prolia

	Concomitant use with other medications for osteoporosis
	N/A
	N/A
	N/A
	Authorization will be for 1 year.
	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre the year.

- Qinlock

- zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 mL

- Remicade

	Concurrent use with Biologic DMARD or Targeted Synthetic DMARD
	Diagnosis, concurrent medication, previous medications tried
	All dx-initial therapy only-Prescribed by or in consult w/RA/AS/Still's/JIA/JRA-rheumatol.Plaque Psor/Pyoderma gangrenosum/HS-dermatol.Psoriatic Arthritis-rheumatol or dermatol.CD/UC-gastroenterol.Uveitis-ophthalmol.GVHD-transplant center, oncol, or hematol.Behcet's- rheumatol, dermatol,ophthalmol, gastroenterol, or neurol.Sarcoidosis-pulmonol, ophthalmol, or dermatol, cardio/neuro.
	All dx-initial therapy only-Prescribed by or in consult w/RA/AS/Still's/JIA/JRA-rheumatol.Plaque Psor/Pyoderma gangrenosum/HS-

	conditions (a and b): a) Patient has a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH), AND b) Patient meets the following criteria [(1) and (2)]: (1) Patient has had a right heart catheterization, AND (2) Results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH.
	All FDA-approved Indications.
	N/A
	No

- Repatha
- Repatha Pushtronex
- Repatha SureClick

	Concurrent use of Leqvio or Praluent.
	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
	N/A
	Approve for 1 year

Hyperlipidemia with HeFH - approve if: pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved u

- Retevmo oral capsule 40 mg, 80 mg

	N/A
	Diagnosis
	Medullary Thyroid Cancer/Thyroid Cancer/Solid tumors-2 years and older, all others 18 years and older
	N/A
	Authorization will be for 1 year

- Rezdiffra

	and ii) has not progressed to stage F4 (cirrhosis) and iii) This will be used in combination with appropriate diet and exercise therapy.
	All FDA-approved Indications.
	N/A
	No

- Rezlidhia

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year

- Rezurock

	N/A
	Diagnosis
	12 years and older
	N/A
	1 year
	Graft-versus-host disease-approve if the patient has chronic graft-versus-host disease and has tried at least two conventional systemic treatments (e.g., ibrutinib, cyclosporine) for chronic graft-versus-host disease.
	All FDA-approved Indications.
	N/A
	No

	beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI and patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3- month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber
	All FDA-approved Indications.
	N/A
	No

- Rinvoq LQ

	Concurrent use with a biologic or with a targeted synthetic DMARD, other potent immunosuppressants, other janus kinase inhibitors, or a biologic immunomodulator.
	Diagnosis
	PsA-2 years and older (initial therapy)
	JIA-prescribed by or in consultation with a rheumatologist (initial therapy). PsA-prescribed by or in consultation with a rheumatologist or a dermatologist (initial therapy)
	Approve through end of plan year
	INITIAL THERAPY: JUVENILE IDIOPATHIC ARTHRITIS (JIA)/ PSORIATIC ARTHRITIS (PsA) - 3-month trial of at least one tumor necrosis factor inhibitor (TNFi) or unable to tolerate a 3-month trial. CONTINUATION THERAPY: ALL INDICATIONS - patient responded to therapy.
	All FDA-approved Indications.
	N/A
	No

- roflumilast

	N/A

- Rozlytrek oral capsule 100 mg, 200 mg
- Rozlytrek oral pellets in packet

	N/A
	Diagnosis
	NSCLC-18 years and older, Solid Tumors-1 month and older, Pediatric Diffuse High-Grade Glioma-less than 18 years old
	N/A
	1 year

Solid Tumors-Approve if the patient's tumor is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND the tumor is metastatic OR surgical resection of tumor will likely result in severe morbidity. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease and the mutation was detected by an approved test. Pediatric Diffuse High-Grade Glioma

- Rubraca

- rufinamide

	N/A
	Diagnosis
	Patients 1 years of age or older
	Prescribed by or in consultation with a neurologist
	1 year
	Initial therapy-approve if rufinamide is being used for adjunctive treatment. Continuation-approve if the patient is responding to therapy
	All FDA-approved Indications, Some Medically-accepted Indications.
	Treatment-Refractory Seizures/Epilepsy
	No

- Rybrevant

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	Authorization will be for 1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Non-Small Cell Lung Cancer (NSCLC) - approve if the pt has epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an approved test OR pt meets both of the following (a and b): a) medication is used as subsequent therapy AND b) pt has one of the following (1, 2, or 3): (1) EGFR exon 19 deletion (2) EGFR exon 21 L858R mutation or (3) EGFR S768I, L861Q, and/or G719X mutation.
	All FDA-approved Indications.
	N/A
	No

- Rydapt

	N/A
	For AML, FLT3 status
	18 years and older
	N/A
	1 year
	AML -approve if the patient is FLT3-mutation positive as detected by an approved test. Myeloid or lymphoid Neoplasms with eosinophilia-approve if the patient has an FGFR1 rearrangement or has an FLT3 rearrangement. All FDA

- Rylaze

	N/A
	Diagnosis
	N/A
	Prescribed by or in consultation with an oncologist
	Authorization will be for 1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Acute lymphoblastic leukemia/lymphoblastic lymphoma/Extranodal NK/T-Cell Lymphoma - approve if the patient has a systemic allergic reaction or anaphylaxis to a pegylated asparaginase product.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Extranodal NK/T-Cell Lymphoma

- Sarclisa

	N/A
	Diagnosis, other therapies
	18 years and older
	Prescribed by or in consultation with an oncologist
	Authorization will be for 1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Multiple myeloma-approve if pt meets (A, B, or C): A) the requested medication will be used as primary therapy in combination with bortezomib, lenalidomide, and dexamethasone, or B) the requested medication will be used in combination with Pomalyst and dexamethasone and the patient has tried at least TWO prior regimens for multiple myeloma and a proteasome inhibitor was a component of at least one previous regimen and Revlimid was a component of at least one previous regimen, or C) medication will be used in combination with Kyprolis and dexamethasone and pt has tried at least one prior regimen.
	All FDA-approved Indications.
	N/A

- Signifor

	N/A
	N/A
	18 years and older (initial therapy)
	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
	Cushing's disease/syndrome-Initial therapy - 4 months, Continuation therapy - 1 year.
	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
	All FDA-approved Indications.
	N/A
	No

- Sirturo

	Patients weighing less than 15 kg
	Diagnosis, concomitant therapy
	Patients 5 years of age or older
	Prescribed by, or in consultation with an infectious diseases specialist
	9 months
	Tuberculosis (Pulmonary) -Approve if the patient has multidrug-resistant tuberculosis or Mycobacterium tuberculosis resistant to at least rifampin and isoniazid, and the requested medication is prescribed as part of a combination regimen with other anti-tuberculosis agents
	All FDA-approved Indications.
	N/A
	No

- Skyrizi intravenous
- Skyrizi subcutaneous pen injector
- Skyrizi subcutaneous syringe 150 mg/mL
- Skyrizi subcutaneous wearable injector 180 mg/1.2 mL (150 mg/mL), 360 mg/2.4 mL (150 mg/mL)

	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)

- diclofenac sodium topical gel 3 %

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 6 months.
	N/A
	All FDA-approved Indications.
	N/A

- Somavert

	N/A
	Diagnosis, previous therapy, concomitant therapy
	N/A
	Prescribed by or in consultation with an endocrinologist

- sorafenib

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 1 year

Bone cancer, approve if the patient has recurrent chordoma or has osteosarcoma and has tried one standard chemotherapy regimen. GIST, approve if the patient has tried TWO of the following: imatinib mesylate, avapritinib, sunitinib, dasatinib, ripretinib or regorafenib. Differentiated (ie, papillary, follicular, HETQq165.29 918.784 0.48 ref*165.05 tried TWO

	All FDA-approved Indications, Some Medically-accepted Indications.
	Bone cancer, Soft tissue sarcoma, gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, ovarian, fallopian tube, primary peritoneal cancer, myeloid/lymphoid neoplasms with eosinophilia
	Yes

- Spravato nasal spray,non-aerosol 56 mg (28 mg x 2), 84 mg (28 mg x 3)

	N/A
	Diagnosis
	18 years and older
	Prescribed by a psychiatrist

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

	N/A
	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For melanoma, cutaneous- KIT mutation and previous therapies.
	GIST/chondrocarcoma or chordoma/ melanoma, cutaneous-18 years and older
	N/A
	Authorization will be for 1 year
	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL. GIST -

	single IV loading dose within 2 months of initiating therapy with Stelara SC) - approve the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one conventional systemic therapy for CD OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).UC, induction therapy, approve if the patient has tried one systemic agent for ulcerative colitis or if the patient has pouchitis and has tried an antibiotic, probiotic, corticosteroid enema or mesalamine enema. UC, initial therapy subcutaneous-before the SC formulation can be approved the patient must have received a single IV loading dose within 2 months of initiating therapy with Stelara SC and try one systemic agent for ulcerative colitis or if the patient has pouchitis and has tried an antibiotic,

	Soft tissue Sarcoma, Osteosarcoma/Ewing Sarcoma, Glioblastoma, Appendiceal cancer
	No

- Strensiq

	N/A
	Diagnosis, genetic and lab test results
	Disease onset-less than or equal to 18
	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of hypophosphatasia or related disorders.
	1 year
	Hypophosphatasia - Perinatal/Infantile- and Juvenile-Onset-Patient must meet both A and B for approval. A) Diagnosis is supported by one of the following (i, ii, or iii): i. Molecular genetic testing documenting tissue non-

- sunitinib malate

	meningioma, thymic carcinoma, pheochromocytoma/paraganglioma, myeloid/lymphoid neoplasms with eosinophilia, GIST-unresectable succinate dehydrogenase (SDH)-deficient GIST, or use after avapritinib.

- SymlinPen 120
- SymlinPen 60

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 1 year
	N/A
	All FDA-approved Indications.
	N/A
	No

- Tabrecta

	N/A
	Diagnosis
	18 years and older
	N/A
	Authorization will be for 1 year

Non-Small Cell Lung Cancer (NSCLC)

- Vyndamax

- Tafinlar oral capsule
- Tafinlar oral tablet for suspension

	N/A
	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
	1 year and older
	N/A
	Authorization will be for 1 year

Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy

	metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following (a, b, or c): a) Multisystem disease OR b) Pulmonary disease OR c) Central nervous system lesions OR patient has Erdheim Chester disease AND patient has BRAF V600-mutation positive disease. Metastatic or solid tumors-approve if BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets) AND patient has no satisfactory alternative treatment options. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer-approve if the patient meets the following (A, B, and C): A) Patient has recurrent disease, AND B) Patient has BRAF V600 mutation-positive disease, AND C) The medication will be taken in combination with Mekinist (trametinib tablets). Hairy Cell Leukemia, approve if pt has not previously been treated with a BRAF inhibitor therapy and this will be used for relapsed/refractory disease and will be taken in combination with Mekinist.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Patients with Differentiated Thyroid Cancer, Biliary tract cancer, central nervous system cancer, histiocytic neoplasm, Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, hairy cell leukemia
	No

- Taltz Autoinjector
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- Talvey

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist

- Talzenna

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Recurrent or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive disease. Prostate cancer - approve if the patient has metastatic castration resistant prostate cancer, AND is using this medication concurrently with a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy AND the patient has homologous recombination repair (HRR) gene-mutated disease [Note: HRR gene mutations include ATM, ATR, BRCA1, BRCA2, CDK12, CHEK2, FANCA, MLH1, MRE11A, NBN, PALB2, or RAD51C] AND the medication is used in combination with Xtandi (enzalutamide capsules and tablets).
	All FDA-approved Indications.
	N/A
	No

- Tecvayli

	N/A
	Diagnosis
	18 years and older

- teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48mL)

	Concomitant use with other medications for osteoporosis
	N/A
	N/A
	N/A

High risk for fracture-2 yrs, Not high risk-approve a max of 2 yrs of therapy (00s165.29 407.95 369.07 32.52 reW*nq165.29 407.95 369.07 32.5

	All FDA-approved Indications, Some Medically-accepted Indications.
	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Kaposi's Sarcoma, Castleman's Disease, histiocytic neoplasms.
	No

- Tibsovo

	N/A
	Diagnosis, IDH1 Status
	All diagnoses (except chondrosarcoma)-18 years and older
	N/A
	1 year

AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test. Cholangiocarcinoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive and has been previously treated with at least one chemotherapy regimen (Part B before Part D Step Therapy - applies only to beneficiaries enrolled in an MA-PD plan). Chondrosarcoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive. Central nervous system cancer

- Tivdak

	N/A
	Diagnosis
	18 years and older
	Prescribed by or in consultation with an oncologist
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Cervical cancer-approve if the patient has tried at least one chemotherapy agent.
	All FDA-approved Indications.
	N/A
	No

- tobramycin in 0.225 % NaCl
- tobramycin inhalation

	N/A
	Diagnosis
	Bronchiectasis, Non-cystic fibrosis-18 years and older
	CF-prescr/consult w/pulm/phys specializes in tx of CF.Bronchiectasis, non CF-prescr/consult w/pulm
	1 year
	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Cystic fibrosis/Bronchiectasis, non-cystic fibrosis-approve if the patient has pseudomonas aeruginosa in the culture of the airway.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Bronchiectasis, non-cystic fibrosis
	No

- tolvaptan

	Concurrent use with Jynarque.
	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
	18 years and older
	N/A
	Authorization will be for 30 days
	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on tolvaptan and has received less than 30 days of therapy.
	All FDA-approved Indications.
	N/A
	No

- pimecrolimus
- tacrolimus topical

	N/A
	N/A
	N/A
	N/A
	Authorization will be for 12 months.
	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
	All Medically-accepted Indications.
	N/A
	No

- tretinoin topical

	Coverage is not provided for cosmetic use.

- Eprontia
- topiramate oral capsule, sprinkle
- topiramate oral tablet
- Zonisade
- zonisamide

	Coverage is not provided for weight loss or smoking cessation.
	N/A
	N/A
	N/A
	Authorization will be for 1 year.
	N/A
	All Medically-accepted Indications.
	N/A
	No

- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr

	Acute (i.e., non-chronic) pain.
	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
	N/A
	N/A
	1 year
	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
	All FDA-approved Indications.

	N/A
	No

- Trelstar intramuscular suspension for reconstitution

	N/A
	Diagnosis

- trientine oral capsule 250 mg

	N/A
	Diagnosis, medication history, pregnancy status, disease manifestations (all as described in Other Criteria)
	N/A
	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
	Authorization will be for 1 year
	For Wilson's Disease, approve if the patient meets A and B: A) Diagnosis of Wilson's disease is confirmed by ONE of the following (i or ii): i. Genetic testing results confirming biallelic pathogenic ATP7B mutations (in either symptomatic or asymptomatic individuals), OR ii. Confirmation of at least two of the following (a, b, c, or d): a. Presence of Kayser-Fleischer rings, OR b. Serum ceruloplasmin levels less than 20mg/dL, OR c. Liver biopsy findings consistent with Wilson's disease, OR d. 24-hour urinary copper greater than 40 micrograms/24 hours, AND B) Patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant, OR 6) the patient has been started on therapy with trientine.
	All FDA-approved Indications.

	N/A
	No

- Truqap

	N/A
	Diagnosis
	18 years and older N/A

- Turalio oral capsule 125 mg

	N/A
	Diagnosis
	18 years and older

- Ubrelvy

	N/A
	Diagnosis
	18 years and older
	N/A
	1 year
	Migraine, Acute treatment-approve
	All FDA-approved Indications.
	N/A
	No

- Valchlor

- Valtoco

	N/A
	Diagnosis, other medications used at the same time
	N/A
	Prescribed by or in consultation with a neurologist
	1 year
	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiseizure medication(s).
	All FDA-approved Indications.
	N/A
	No

- Verzenio

	N/A
	Breast cancer: HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
	18 years and older
	N/A
	1year
	Breast Cancer, Early-Approve if pt meets (A,B,C and D): A)Pt has HR+disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt has node-positive disease at high risk of recurrence AND D)Pt meets ONE of the following (i or ii): i.Verzenio will be used in combo w/anastrozole, exemestane, or letrozole AND pt meets one of the following (a,b, or c): a)Pt is a postmenopausal woman, OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, OR 2-Pt has had surgical bilateral oophorectomy or ovarian irradiation, OR c)Pt is a man and pt is receiving a GnRH analog, OR ii.Verzenio will be used in combo with tamoxifen AND pt meets one of the following (a or b): a)Pt i

- Vimizim

	N/A
	Diagnosis, genetic and lab test results
	N/A
	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.
	1 year
	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine-6-sulfatase activity in leukocytes or fibroblasts OR

- Vistogard

	N/A
	Diagnosis
	N/A
	N/A
	7 days
	Capecitabine or fluorouracil overdose-approve. Capecitabine or fluorouracil toxicity, severe or life threatening-approve.
	All FDA-approved Indications.
	N/A
	No

- Vitrakvi oral capsule 100 mg, 25 mg
- Vitrakvi oral solution

- Vizimpro

	N/A
	Diagnosis, EGFR status, exon deletions or substitutions
	18 years and older
	N/A
	1 year NSCLC-

- Vosevi

	N/A
	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
	18 years or older
	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
	Criteria will be applied consistent with current AASLD/IDSA guidance.
	All FDA-approved Indications, Some Medically-accepted Indications.
	Indications consistent with current AASLD/IDSA guidance
	No

- pazopanib
- Votrient

	N/A
	N/A
	18 years and older
	N/A
	1 year

Soft tissue sarcoma other than GIST-approve if the patient has advanced or metastatic disease and has ONE of the following: alveolar soft part sarcoma, angiosarcoma, desmoid tumors (aggressive fibromatosis, dermatofibrosarcoma protuberans with fibrosarco7.03s66.144 439.27 0.13fc

	Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary thyroid carcinoma, bone cancer.

	NSCLC with high level MET amplification or MET Exon 14 skipping mutation, Histiocytic neoplasms, melanoma, cutaneous.
	No

- Xeljanz oral solution
- Xeljanz oral tablet
- Xeljanz XR

	one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber.
	All FDA-approved Indications.
	N/A
	No

- Xermelo

	N/A
	Diagnosis, previous therapy, concomitant therapy
	N/A
	N/A
	1 year

- Xiaflex