CDPHP Medicare Advantage
2021 Part D Prior Authorization Criteria

The following guidelines outline the Part D drugs that require prior authorization through the CDPHP pharmacy department. ***Please be aware that these guidelines do not reflect those instances in which it is the member's responsibility to seek prior authorization.***

Coverage for a service is subject to the member's eligibility, specific contract benefits, and CDPHP policy. Requests for a service that does not meet criteria outlined in the CDPHP Medicare Advantage pharmacy policies or for an extension beyond what has been approved by CDPHP should be directed to the pharmacy department at (518) 641-3784.

POLICIES **Policy Reference/Type of Service Requiring Prior Authorization**	**Effective Date: July 1, 2021**
abiraterone (ZYTIGA) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ACNE 1350/20.000118 • *avita cream/gel* • *tretinoin cream/gel*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** Enrollee has tried or prescriber has considered using one of the accepted therapies noted in national guidelines, including, but not limited to topical benzoyl peroxide, topical antibiotics, systemic antibiotics but deemed one or all of them inappropriate for the enrollee. **Exclusions:** Cosmetic Use. **Approvals:** 12 months.
ACTIMMUNE (Interferon-Gamma 1B) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ADEMPAS (riociguat) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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AIMOVIG (erenumab) **1350/20.000346**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Criteria:** The requested drug will be covered when the following criteria are met: 1) The requested drug is being prescribed for the preventative treatment of migraine in an adult patient AND a) The patient has experienced an inadequate treatment response with an 8 week trial of any of the following: anti epileptic drugs, beta-adrenergic blockers, antidepressants OR b) the patient received at least 3 months of treatment with the requested drug and the patient has had a reduction in migraine days per month from baseline. **Exclusions:** None. **Prescriber Restrictions:** Must be prescribed by a neurologist, headache specialist, pain specialist. **Approvals:** Initial approval 3 months, continuation 12 months.
ALDURAZYME (laronidase) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ALECENSA (alectinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ALPHA-1-PROTEINASE INHIBITOR (ARALAST NP, PROLASTIN-C, ZEMAIRA) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ALUNBRIG (brigatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ambrisentan (LETAIRIS) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months**.**
ANADROL (oxymetholone) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
APOKYN (apomorphine) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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ARANESP (darbepoetin) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ARCALYST (rilonacept) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
armodafinil 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
AURYXIA (ferric citrate) 1350/20.000330	**Covered indications:** For the control of serum phosphorous levels in adult patients with chronic kidney disease on dialysis. **Exclusions:** Auryxia is not considered to be eligible for coverage under Part D when used for the treatment of iron deficiency anemia in patients with chronic kidney disease not on dialysis. Auryxia is contraindicated in patients with iron overload syndromes (hemochromatosis). **Approvals:** 12 months.
AUSTEDO (deutetrabenazine) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
AVASTIN (bevacizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
AYVAKIT (avapritinib) tabs 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
BALVERSA (erdafitinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
BENLYSTA (belimumab) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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BENZODIAZEPINES **1350/20.000254** • *clorazepate* • *diazepam* • *diazepam intensol* *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria**: If being used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient must have experienced an inadequate treatment response to one formulary drug indicated for anxiety including, but not limited to, buspirone, duloxetine, escitalopram, venlafaxine, or paroxetine AND if the patient is 70 years of age or older, the benefit of therapy with the prescribed medication must outweigh the potential risk. **Exclusions**: None **Approvals**: As listed depending upon diagnosis: Alcohol withdrawal—1 month Anxiety—6 months Muscle spasms/Reflex—6 months Neuron disorder/Seizures—Plan year
BERINERT (c1 esterase inhibitor) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
bexarotene (bexarotene caps, Targretin Gel) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
bosentan 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals:** 12 months.
BOSULIF (bosutinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
BRAFTOVI (encorafenib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
BRIVIACT (brivaracetam) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.

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BRUKINSA (zanubrutinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CABOMETYX (cabozantinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CALQUENCE (acalabrutinib) capsules 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CAPRELSA (vandetanib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CARBAGLU (carglumic acid) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
CERDELGA (eliglustat) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
CEREZYME (imiglucerase) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
clobazam 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
COMETRIQ (cabozantinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
COPIKTRA (duvelisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.

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COTELLIC (cobimetinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CYSTAGON (cysteamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
CYSTARAN (cysteamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
DAURISMO (glasdegib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
deferasirox 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
DHE Nasal Spray (dihydroergotamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
DIACOMIT (stiripentol) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
DOPTELET (avatrombopag) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
DRIZALMA (duloxetine sprinkle caps) 1350/20.000376 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications and some Medically-Accepted Indications. **Off-label Uses:** Cancer pain, chemotherapy induced neuropathic pain. **Required Medical Info:** The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration) **Age Restrictions:** GAD - ages 7 years and older **Exclusions:** None **Approvals:** 12 months.

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DRUGS REQUIRING PRIOR AUTHORIZATION 1350/20.000278	CDPHP requires prior authorization for certain drugs before they will be approved for coverage. All drugs requiring prior authorization have been approved through the Centers for Medicare and Medicaid Services (CMS) via the formulary submission process. If there is not a specific Medicare Advantage policy in effect which describes the criteria for prior authorization approval, prior authorization will be approved for one of the following as per submission: All FDA approved indications not otherwise excluded from Part D OR All Medically-Accepted indications (FDA approved and compendia-supported).
ENBREL (etanercept) 1350/20.000161	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Criteria:** Plaque Psoriasis- Must cover at least 5% body surface area (BSA) or affecting crucial body areas such as the hands, feet, face or genitals, patient must have failed on 2 therapies either systemic therapies including oral methotrexate, retinoids, cyclosporine and hydroxyurea, or topical therapies such as topical corticosteroids, vitamin D analogs or calcineurin inhibitors. **Age Restrictions:** Psoriasis – Approve for those 4 years of age or older, Polyarticular juvenile idiopathic arthritis – Approve for those 2 years of age and older **Prescriber Restrictions:** Rheumatologist or Dermatologist **Approvals:** 12 months
ENDARI (l-glutamide) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
EPCLUSA (sofosbuvir/velpatasvir) 1350/20.000311	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Prescriber Restrictions:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist. **Exclusions:** None. **Approvals:** Approval duration will be applied consistent with AASLD/IDSA guidance. **Other Criteria:** Coadministration of omeprazole or other proton-pump inhibitors is not recommended. If it is medically necessary to coadminister, Epclusa and/or sofosbuvir-velpatasvir (brand or generic) should be administered with food and taken 4 hours before omeprazole 20mg.
EPIDIOLEX (cannabidiol) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals:** 12 months.

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ERIVEDGE (vismodegib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** 12 months.
ERLEADA (apalutamide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
erlotinib 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months**.**
ESBRIET (pirfenidone) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
everolimus 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
FABRAZYME (agalsidase) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
FARYDAK (panobinostat) caps 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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fentanyl 1350/20.000327 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Current utilization of medication assisted therapy to treat opioid use disorder or alcohol use disorder **Criteria**: Covered if being prescribed for pain associated with cancer, a terminal condition or pain being managed through hospice or palliative care OR for non-cancer pain the patient has a history of a trial with a short acting opioid indicating they can safely take the requested dose AND the patient has been evaluated and will be monitored for the development of opioid use disorder. For the management of chronic severe pain in opioid-tolerant patients who require daily, around the clock, long- term opiate treatment. Opioid tolerant is defined as those taking, for a minimum of 1 week, at least 60mg/day oral morphine, 30mg/day oral oxycodone, 8mg/day oral hydromorphone, 25mg/day oral oxymorphone, 60mg/day oral hydrocodone or an equivalent dose of another opioid. Due to the risks of addiction, abuse, and misuse of opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, fentanyl should be reserved for use in patients for whom at least 2 alternative treatment options (ie. non-opioid analgesics or immediate release opioids) are ineffective, not tolerated or would be otherwise inadequate to provide sufficient management of pain. **Approvals:** Pain with cancer, terminal conditions, hospice/palliative care = 12 months. Non-Cancer Pain = 6 months
filgrastim 1350/20.000171 • *Zarxio*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Treatment of acute afebrile neutropenia. **Approvals:** 3 months.
FINTEPLA (fenfluramine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
FOTIVDA (tivozanib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
FYCOMPA (perampanel) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
GATTEX (teduglutide) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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GAVRETO (pralsetinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
GILOTRIF (afatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and from Part D. **Exclusions:** None. **Approvals:** 12 months.
GROWTH HORMONE 1350/20.000134 • *NORDITROPIN*	**Covered indications**: All Medically-Accepted Indications (FDA approved and from Part D. **Criteria**: Prescriber must be an endocrinologist, HIV, or infectious disease specialist. Must lack adequate endogenous growth hormone secretion both prior to treatment and throughout the course of any growth hormone therapy as evidenced by growth hormone stimulation tests. The presenting height must be below the fifth percentile for children. There must be radiographically-documented evidence of delayed bone age (for children). **Exclusions**: Patient must not have severe respiratory impairment/sleep apnea associated with Prader-Willi syndrome. **Approvals**: 12 months.
HAEGARDA (c1 esterase inhibitor, human) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and from Part D. **Exclusions:** None **Approvals:** 12 months.
HARVONI (ledipasvir-sofosbuvir) 1350/20.000313	**Covered indications:** All Medically-Accepted Indications (FDA approved and from Part D. **Prescriber Restrictions:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **Exclusions:** None **Approvals:** Approval duration will be applied consistent with AASLD/IDSA guidance. **Other Criteria:** Proton pump inhibitor doses comparable to omeprazole 40mg or higher cannot be administered simultaneously with Harvoni and/or ledipasvir-sofosbuvir (brand or generic) under fasted conditions.
HERCEPTIN (trastuzumab) injection 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
HERCEPTIN HYLECTA (trastuzumab-hyaluronidase) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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HERZUMA (trastuzumab-pkrb) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
HETLIOZ (tasimelteon) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
HIGH RISK MEDICATIONS **1350/20.000242** • *benztropine* • *carisoprodol* • *clomipramine* • *cyclobenzaprine* • *cyproheptadine tabs/syrup* • *hydroxyzine hcl injection* • *hydroxyzine hcl syrup/tabs* • *hydroxyzine pamoate caps* • *megestrol susp 625mg/5ml* • *phenobarbital tab,elixir,injection* • *promethazine tab, syrup, injection, suppository* • *trihexyphenidyl tabs, elixir* *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and from Part D. **Criteria:** The American Geriatrics Society identifies the use of these medications as potentially inappropriate in older adults, meaning they are best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Prescriber is notified that the medication is high risk and still wishes to continue therapy. Prior authorization applies only to patients 70 years of age or older. **Exclusions**: None **Approvals**: 12 months.
HRM Hypnotics 1350/20.000363 • *eszopiclone* • *zaleplon* • *zolpidem*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** This Prior Authorization requirement only applies to patients 70 years of age or older after and after a cumulative 90 day supply is filled within the year. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. **Exclusions:** Patients who have previously experienced complex sleep behaviors (sleep walking, sleep driving and engaging in other activities while not fully awake) after taking eszopiclone, zaleplon or zolpidem. **Approvals:** 12 months.

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HUMIRA (adalibumab) 1350/20.000164	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** Psoriasis—Must cover at least 5% of body surface area (BSA) or affecting crucial body areas such as hands, feet, face or genitals, patient must have failed OR be a candidate for EITHER systemic or topical therapy. Crohn's disease—patient must demonstrate an inadequate response to one conventional therapy—examples include (but not limited to) oral aminosalicylates, corticosteriods, budesonide, azathioprine, metronidazole, infliximab and adalibumab. Ulcerative Colitis- patient must demonstrate an inadequate response to immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine. **Prescriber Restrictions:** Prescriber must be Rheumatologist, Dermatologist, Gastroenterologist or Ophthalmologist. **Age Restrictions:** Crohn's- Approve for those 6 years of age and older. Hidradenitis suppurativa- Approve for those 12 years of age and older. Juvenile Idiopathic Arthritis and Uveitis- Approve for those 2 years of age and older. **Approvals:** 12 months.
IBRANCE (palbociclib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
icatibant 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and **compendia-supported)**. **Exclusions:** None **Approvals:** 12 months**.**
ICLUSIG (ponatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
IDHIFA (enasidenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
Imatinib 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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IMBRUVICA (ibrutinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
IMMEDIATE RELEASE FENTANYL 1350/20.000281 • *fentanyl citrate buccal tabs* • *fentanyl lozenges*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Criteria:** Must be used for the management of breakthrough pain patients with cancer, who are already receiving, and who are tolerant to, around the clock opioid therapy for their underlying persistant pain. **Prescriber Restrictions:** Oncologist, hematologist, pain management or palliative care. **Exclusions:** None **Approvals:** 12 months.
INBRIJA (levodopa) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
INCRELEX (mecasermin, recombinant) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
INGREZZA (valbenazine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
INLYTA (axitinib) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
INQOVI (decitabine/cedazuridine) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
INREBIC (fedratinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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IRESSA (gefitinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
JAKAFI (ruxolitinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
JUXTAPID (lomitapide) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
KALYDECO (ivacaftor) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
KANJINTI (trastuzumab-anns) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
KEYTRUDA (pembrolizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
KISQALI (ribociclib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
KISQALI PAK 200/400/600 FEMARA (ribociclib-letrozole) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
KORLYM (mifepristone, RU486) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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KUVAN (sapropterin) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
KYNMOBI (apomorphine) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
LENVIMA (lenvatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
Lidocaine patches 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
long acting opiates 1350/20.000328 • *methadone* • *morphine ER* *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Current utilization of medication assisted therapy to treat opioid use disorder or alcohol use disorder **Criteria:** Covered if being prescribed for pain associated with cancer, a terminal condition or pain being managed through hospice or palliative care OR for non-cancer pain the patient has a history of a trial with a short acting opioid indicating they can safely take the requested dose AND the patient has been evaluated and will be monitored for the development of opioid use disorder AND this is a continuation of therapy for a patient who has received an ER opiate for 30+ days OR the patient has received 1 week of an immediate release opiate and has severe continuous pain. For the management of chronic severe pain in opioid-tolerant patients who require daily, around the clock, long- term opiate treatment. Opioid tolerant is defined as those taking, for a minimum of 1 week, at least 60mg/day oral morphine, 30mg/day oral oxycodone, 8mg/day oral hydromorphone, 25mg/day oral oxymorphone, 60mg/day oral hydrocodone or an equivalent dose of another opioid. Extended release morphine, methadone tablets or methadone oral solution should be reserved for when at least 2 alternative treatment options (ie. non-opioid analgesics or immediate release opioids) are ineffective, not tolerated or would be otherwise inadequate to provide sufficient management of pain. **Approvals:** Pain with cancer, terminal conditions, hospice/palliative care = 12 months. Non-Cancer Pain = 6 months

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LONSURF (trifluridine/tipiracil) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
LORBRENA (lorlatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
LUMIZYME (alglucosidase alfa) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
LYNPARZA (olaparib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
MAVENCLAD PAK (cladribine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
MAVYRET (glecaprevir/pibrentasvir) 1350/20.000314	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Prescriber Restrictions:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **Exclusions:** None **Approvals:** Approval duration will be applied consistent with AASLD/IDSA guidance.
MEKINIST (trametinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
MEKTOVI (binimetinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
MEMANTINE 1350/20.000284	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** This edit only applies to patients less than 30 years of age. **Exclusions:** None **Approvals:** 12 months.

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miglustat 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
MONJUVI (tafasitamab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
MVASI (bevacizumab-awwb) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
NAGLAZYME (galsulfase) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
NATPARA (parathyroid hormone) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
NERLYNX (neratinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
NEXAVAR (sorafenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
NINLARO (ixazomib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
nitisinone 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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NORTHERA (droxidopa) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
NUBEQA (darolutamide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
NUCALA (mepolizumab) 1350/20.000364	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** Acute bronchospasm or status asthmaticus **Criteria:** For diagnosis of severe asthma the enrollee must have an eosinophilic phenotype characterized by: a. Sputum eosinophil count of 3% or more OR blood eosinophil count greater than or equal to 150 cells/mcL at screening or greater than or equal to 300 cells/mcL within 12 months of starting. The enrollee must not currently use tobacco products. The enrollee must not have had a parasatic infection within the last 6 months. Approval will be contingent on the continued use of standard of care for asthma (inhaled corticosteroids and additional controlled medications such as long acting beta agonist inhalers). Nucala is not FDA approved as monotherapy. **Age Restrictions:** Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss Syndrome) 18 years and older, Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype **Prescriber Restrictions:** Pulmonologist, allergist, immunologist, rheumatologist **Approvals:** 6 months, continutation requires documentation of clinical improvement or sustained efficacy
NUEDEXTA (dextromethorphan; quinidine) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
NUPLAZID (pimavanserin) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ODOMZO (sonidegib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
OFEV (nintedanib) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.

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OGIVRI (trastuzumab-dkst) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ONTRUZANT (trastuzumab-dttb) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ONUREG (azacitidine) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
OPSUMIT (macitentan) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
ORGOVYX (relugolix) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ORKAMBI (lumacaftor/ivacaftor) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
OXERVATE (cenegermin) **1350/20.000369**	**Covered indications:** Neurotrophic Keratitis **Age Restrictions:** Ages 2 and older **Prescriber Restrictions:** Ophthalmologist **Approvals:** 8 weeks.
PEGASYS (peginterferon alfa 2a) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
PEMAZYRE (pemigatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
PHENYLBUTYRATE 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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PHESGO (hyaluronidase-zzxf, pertuzumab, trastuzumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
PIQRAY (alpelisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
POMALYST (pomalidomide) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
PRALUENT (alirocumab) 1350/20.000326	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals:** 12 months.
PROLIA (denosumab) 1350/20.000235	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Criteria:** For osteoporosis treatment, patients must be at high risk for osteoporotic fracture defined as a previous history of osteoporosis related fracture or a T score of less than or equal to 2.5 or a T-score between -1 and -2.5 with a 10 year hip fracture probability greater than 3% or 10-year major osteoporosis-related fracture probability greater than 20% based on FRAX score and must show failure of six months or more of therapy with a bisphosphonate defined as an osteoporotic fracture while on therapy or a significant reduction in BMD while on therapy, or the patient has a contraindication to bisphosphonates. Contraindications to bisphosphonates include renal insufficiency with a eGFR or estimated creatinine clearance of less than 35 ml per minute or a contraindication to oral bisphosphonate because of an inablility to remain upright for the required 30 to 60 minutes following an oral dose, or esophageal abnormalities that delay esophageal emptying, Barrett's esophagus, or espohageal ulceration. For use to increase bone mass in women at high risk for fracture who are receiving adjuvant aromatase inhibitor therapy for breast cancer, must demonstrate having a baseline BMD T score of -1 to -2.5 at the lumbar spine, total hip, or femoral neck. For use to increase bone mass in men at high risk for fracture who are receiving androgen deprivation therapy for nonmetastatic prostate cancer, must demonstrate having a BMD T score at the lumbar spine, total hip, or femoral neck between -1 and -4 or having a history of an osteoporotic fracture. Must be 18 years or older. Should be administered by a healthcare professional. Dosing is a subcutaneous injections of 60 mg every 6 months. **Age Restrictions:** Approved for those 18 years of age or older. **Exclusions:** None. **Approvals:** 12 months.

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PROMACTA (eltrombopag olamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** 12 months.
PULMONARY ARTERIAL HYPERTENSION 1350/20.000123 • *sildenafil tabs, suspension* *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Prescriber Restrictions:** Cardiologist or pulmonologist **Exclusions:** Concurrent use with a nitrate or nitrous oxide donor, or concur rent use of PDE inhibitor with a soluble guanylate cyclase stimulator. **Approvals:** 12 months.
QINLOCK (ripretinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
Quinine sulfate 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
REMICADE (infliximab) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
RENFLEXIS (infliximab-ABDA) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
REPATHA (evolocumab) 1350/20.000340	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals**: 12 months.

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RETACRIT (epoetin alfa-EPBX) **1350/20.000365**	**Covered Indications:** For patients with CKD and NOT on dialysis, consider initiating EPO treatment only when the Hgb level is less than 10g/dl and the following considerations apply: If the Hgb level exceeds 10g/dl, reduce or interrupt the dose of EPO. For patients with CKD and on dialysis initiate the treatment of EPO when the Hgb level is less than 10g/dl. If the Hgb level approaches or exceeds 11 g/dl, reduce or interrupt the dose of EPO. For patients on cancer chemotherapy initiate EPO only if the Hgb is less than 10g/dl and if there is a minimum of 2 additional months of planned chemotherapy. If there is no response as measured by Hgb levels or if RBC transfusions are still required after 8 weeks of therapy and following the completion of chemotherapy, EPO should be discontinued. For HIV patients treated with zidovudine, withhold EPO if Hgb levels exceed 12 g/dl. For patients undergoing elective surgery, Hgb should be greater than 10 but less than 13 g/dl. **Exclusions:** All indications: excluded if patient has uncontrolled hypertension. In patients with cancer receiving hormonal agents, biologic products, or radiotherapy unless also receiving concomitant myelosuppressive chemotherapy. In patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure. In patients with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion. In patients scheduled for surgery who are willing to donate autologus blood. In patients undergoing cardiac or vascular surgery. As a substitute for RBC transfusions in patients who require immediate correction of anemia. **Approvals:** Initial therapy and/or dose changes- 12 weeks. Stable on therapy, CRF- 24 weeks. Anemia of cancer- 12 weeks.
RETEVMO (selpercatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
REVLIMID (lenalidomide) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RIABNI (rituximab-arrx) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
RINVOQ (upadacitinib) **1350/20.000278**	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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RITUXAN (rituximab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
RITUXAN HYCELA (rituximab/ hyaluronidase) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ROZLYTREK (entrectinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RUBRACA (rucaparib) tablets 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
RUXIENCE (rituximab-pvvr) injection 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
RYDAPT (midostaurin) capsules 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
SIGNIFOR (pasireotide) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.
SIRTURO (bedaquiline) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: 12 months.
SKYRIZI (risankizumab rzaa) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: 12 months.

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SPRYCEL (dasatinib) **1350/20.000184** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Age Restrictions:** Approved for those 18 years of age or older for Ph+CML-CP, PH+ ALL resistant or intolerant to prior therapy, chronic, accelerated or myeloid or lymphoid blast phase PH+CML with resistance or intolerance to prior therapy including imatinib, Approved for those 1 year of age or older in pediatric patients with Ph+ CML in chronic phase and for pediatric patients with newly diagnosed Ph+ ALL in combination with chemotherapy **Approvals:** 12 months.
STEP THERAPY POLICY **1350/20.000268**	The step therapy program includes the following criteria: The drugs subject to step therapy and the prerequisite therapy necessary for coverage of these drugs will be determined by the CDPHP pharmacy and therapeutics committee. If it is medically necessary for an enrollee to use a step therapy drug as initial therapy without trying the prerequisite therapy, the prescribing practitioner can request coverage for this drug using the standard medical exception process. The list of drugs that require step therapy is available online at www.cdphp.com under the Rx Corner section of the Provider tab or through the pharmacy department at CDPHP.
STELARA (ustekinumab) **1350/20.000366**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** For moderate to severe plaque psoriasis (new starts only) at least 5% of body surface area (BSA) is affected OR crucial body areas (feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND the patient had an inadequate response, intolerance, or contraindication to at least two of the following: Enbrel, Humira or Skyrizi. For active psoriatic arthritis (PsA) (new starts only) the patient had an inadequate response, intolerance, or contraindication to at least two of the following: Enbrel, Humira, Xeljanz/Xeljanz XR. For moderately to severely active Crohn's disease (new starts only) patient had an inadequate response, intolerance, or contraindication to Humira. For ulcerative colitis (new starts only) patient had an inadequate response, intolerance or contraindication to Humira AND Xeljanz/Xeljanz XR. **Age Restrictions:** Plaque Psoriasis—6 years of age and older. Psoriatic Arthritis or Crohn's—18 years of age and older. **Prescriber Restrictions:** Gastroenterologist, Rheumatologist or Dermatologist. **Approvals:** 12 months.
STIVARGA (regorafenib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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SUTENT (sunitinib malate) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
SYMDEKO (tezacaftor-ivacaftor) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
SYMPAZAN (clobazam) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** 12 months.
SYNRIBO (omacetaxine) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TABRECTA (capmatinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TAFINLAR (dabrafenib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TAGRISSO (osimertinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TALTZ (ixekizumab) 1350/20.000374	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). For moderate to severe plaque psoriasis at least 5% of body surface area (BSA) is affected OR crucial body areas (feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND the patient had an inadequate response, intolerance, or contra-indication to one of the following: Enbrel, Humira or Skyrizi. For active psoriatic arthritis (PsA) the patient had an inadequate response, intolerance, or contraindication to one of the following: Enbrel, Humira , Xeljanz/Xeljanz XR. For ankylosing spondylitis the patient had an inadequate response, intolerance, or contraindication to one of the following: Enbrel or Humira. Active non-radiographic axial spondyloarthritis (nr-axSpA) is covered with no prior treatment required. **Prescriber Restrictions:** Rheumatologist, Dermatologist **Exclusions:** None **Approvals:** 12 months.

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TALZENNA (talazoparib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TASIGNA (nilotinib) 1350/20.000181 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Age Restrictions:** Newly diagnosed Ph+CML in CP: Approved for adults and pediatric patients greater or equal to 1 year of age. Accelerated Phase (AP) Ph+CML resistant/intolerant: Approved for those 18 years of age or older. Ph+CML-CP resistant/intolerant to prior TKI therapy: Approved for adults and pediatric patients greater or equal to 1 year of age. **Approvals:** 12 months.
TAZVERIK (tazemetustat) 1350/20.000278 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TECENTRIQ (atezolizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
TEPMETKO (tepotinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TETRABENAZINE 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
THALOMID (thalidomide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TIBSOVO (ivosidenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TRAZIMERA (trastuzumab-qyyp) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.

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TRIKAFTA (elexacaftor/tezacaftor/ivacaftor) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TRUXIMA (rituximab-abbs) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
TUKYSA (tucatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TURALIO (pexidartinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TYKERB (lapatinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
TYSABRI (natalizumab) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
UBRELVY (ubrogepant) 1350/20.000346	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Criteria:** The requested drug will be covered when the following criteria are met: 1) The requested drug is being prescribed for the acute treatment of migraine in an adult patient AND the patient has a history of 2 to 8 migraines per month with moderate to severe headache pain in the previous 3 months AND the patient has had failure with at least two different formulary triptan agents at maximally indicated dose unless contraindicated. **Exclusions:** None **Prescriber Restrictions:** Must be prescribed by a neurologist, headache specialist, pain specialist. **Approvals:** Initial approval 3 months, continuation 12 months.
UKONIQ (umbralisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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VALCHLOR (mechlorethamine) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VELCADE (bortezomib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
VELTASSA (patiromer sorbitex) **1350/20.000392**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Info:** Patient must have tried and failed Lokelma **Exclusions:** None **Approvals:** 12 months.
VENCLEXTA (venetoclax) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VENTAVIS (iloprost) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VERZENIO (abemaciclib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
vigabatrin 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
VITRAKVI (larotrectinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
VIZIMPRO (dacomitinib) **1350/20.000278** *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir) 1350/20.000315	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Prescriber Restrictions:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **Exclusions:** None **Approvals:** Approval duration will be applied consistent with AASLD/IDSA guidance. **Other Criteria:** Omeprazole 20mg can be administered with Vosevi. Use with other proton-pump inhibitors has not been studied.
VOTRIENT (pazopanib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
XALKORI (crizotinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** 12 months.
XELJANZ (tofacitinib) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions**: None **Approvals:** 12 months.
XGEVA (denosumab) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.

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XOLAIR (omalizumab) 1350/20.000125	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Criteria:** Asthma: Documented evidence of reversible airway disease, IgE level greater or equal to 30 and less than or equal to 700 IU/ ml for ages greater than or equal to 12 years old, for patients 6 to 12 years old IgE level greater or equal to 30 and less than or equal to 1300 IU/ ml evidence of specific allergic sensitivity by a positive skin or blood test for specific IgE. Chronic idiopathic urticaria-CIU-documented evidence of daily or almost daily wheals and itching for at least 6 weeks with no obvious cause. Asthma: Inadequately controlled on medium-dose inhaled corticosteroid in combination with a long acting inhaled beta agonist (LABA) or leukotriene receptor agonist, theophylline or Zileuton unless intolerant or contraindicated. CIU- must have documented trial and failure or inadequate control for at least 3 months of therapy of H1 with or without H2 antihistamines unless intolerant or contraindicated. Dose is administered once every 28 days. Asthma and CIU- Patient must be instructed regarding the signs and symptoms of anaphylaxis. If the medication is being obtained at a retail pharmacy it may be covered under Part D if the following conditions are satisfied: A physician is administering the medication and he/she agree to accept brown bagging of the medication and understands that the member will obtain the medication from a pharmacy and have it in their possession until it is delivered to the physician office or clinic for administration (ie pharmacy ships drug to member). If the medication is shipped from the specialty pharmacy directly to the office/clinic it will be covered as a Part B benefit. **Exclusions:** None. **Age Restrictions:** Asthma: Approved for those 6 years of age or older. CIU: Approved for those 12 years of age or older. **Approvals:** 12 months.
XOSPATA (gilteritinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
XPOVIO (selinexor) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.

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XTANDI (enzalutamide) 1350/20.000265 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Criteria:** Patient must have failed or have a contraindication to Zytiga therapy for metastatic castration resistant prostate cancer (CRPC) only. For non-metastatic castration-resistant prostate cancer no previous failure of Zytiga is required **Approvals:** 12 months.
XYREM (sodium oxybate) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
ZEJULA (niraparib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZELBORAF (vemurafenib) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
ZIRABEV (bevacizumab-bvzr) injection 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D **Exclusions**: None **Approvals**: 12 months.
ZOLINZA (vorinostat) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: 12 months.
ZYDELIG (idelalsib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZYKADIA (ceritinib) capsules/tabs 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** 12 months.
ZYPREXA RELPREVV (olanzapine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.