CDPHP Medicare Advantage
2023 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: January 1, 2023**
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:** Indefinitely until plan enrollment ended.
ACNE 1350/20.000118 • *avita cream/gel* • *tretinoin cream/gel*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Info:** 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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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AIMOVIG (erenumab) **1350/20.000346**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Required Medical Info:** 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:** None. **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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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**: Indefinit**ely until plan enrollment ended.**
ARANESP (darbepoetin) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
ARCALYST (rilonacept) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.

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armodafinil 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
AURYXIA (ferric citrate) 1350/20.000330	**Covered indications:** The patient is 18 or older and has a diagnosis of hyperphosphatemia in 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) 1350/20.000419	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Significant risk for suicidal or violent behavior or unstable psychiatric symptoms. Enrollee must not have dual therapy with other vesicular monoamine transporter 2 (VMAT) inhibitors or concomitant use of a monoamine oxidase inhibitor (MAOI). **Age Restrictions:** 18 years and older **Prescriber Restrictions:** Psychiatrist or neurologist **Approvals:** Initial approval 3 months. Renewal requests if policy criteria met 6 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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
BANZEL (rufinamide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.

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BENLYSTA (belimumab) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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). **Required Medical Info**: 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:** Indefinitely until plan enrollment ended.
BESREMI (ropeginterferon alfa 2b) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** Indefinitely until plan enrollment ended.
bexarotene (bexarotene caps, gel) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
CAMZYOS (mavacamten) capsules **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
CARBAGLU (carglumic acid) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
CERDELGA (eliglustat) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
CEREZYME (imiglucerase) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.

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clobazam 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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COSENTYX (secukinumab) **1350/20.000457**	**Covered indications:** All FDA-approved indications and some Medically-Accepted Indications. **Required Medical Info:** **Criteria for initial approval require ALL of the following:** 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient has been treated with the requested agent within the past 90 days OR B. Prescriber states the patient has been treated with the requested agent AND is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's diagnosis does NOT require a conventional prerequisite agent OR E. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR G. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator **Criteria for renewal approval require ALL of the following:** 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator **Exclusions:** FDA labeled contraindications to the requested agent **Other Criteria:** Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis or plaque psoriasis, NO prerequisites are required for diagnoses of ankylosing spondylitis, enthesitis related arthritis, or non-radiographic axial spondyloarthritis. Formulary conventional agents for psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine. Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids. **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:** Indefinitely until plan enrollment ended.
CYSTAGON (cysteamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
CYSTARAN (cysteamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
deferasirox 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
DHE Nasal Spray (dihydroergotamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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DOPTELET (avatrombopag) 1350/20.000422	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Required Medical Information:** Chronic liver disease- enrollee has platelet count below 50 x 109/L obtained within four weeks prior to procedure AND is undergoing invasive procedure that has at least a moderate risk of bleeding associated, OR is undergoing a low bleeding risk procedure with a personal history of clinically relevant bleeding requiring intervention. Doptelet is started 10-13 days prior to procedure and enrollees should undergo procedure 5-8 days after the last dose. Chronic immune thrombo cytopenia- enrollee has a diagnosis of thrombocytopenia lasting more than 12 months. Current (within 30 days) platelet count less than 30 x 109/L. Enrollee has had an insufficient response or is intolerant to corticosteroids AND IVIG at maximally recommended doses OR enrollee has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. PT/INR and aPTT must have been within 80-120% of the normal range with no history of hypercoagulable state. Enrollee will not be eligible for future re-treatment if considered a non-responder to the initial course of therapy (non-responder defined as requiring platelet transfusion following PTO receptor agonist therapy). Response to treatment for chronic ITP defined as a platelet count greater than 50 x 109/L. Discontinue if the platelet count does not increase to greater than or equal to 50 X 109/L after 4 weeks of dosing at the maximum dose. **Exclusions:** Enrollees undergoing procedures that have a low risk of bleeding associated. Enrollees undergoing procedures including laparotomy, thoracotomy, open-heart surgery, craniotomy or organ resection. Doptelet has been approved for use for 5 days only and should not be given to those with CLD in an attempt to normalize platelet counts. Enrollees with thrombotic or thromboembolic complications **Prescriber Restrictions:** Prescribed by or in consultation with a hematologist, hepatologist, or surgeon **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 **Required Medical Info:** 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) 1350/20.000421	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Information:** Sickle cell anemia- must be prescribed alongside hydroxyurea unless significant intolerance or contraindication exists AND enrollee has had at least 2 or more painful sickle cell crises within the previous 12 months while adherant on hydroxyurea therapy. **Age Restrictions:** 5 and older. **Prescriber Restrictions:** Must be prescribed by or in consultation with SCD specialist or a hematologist. **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.

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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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
erlotinib 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**

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ESBRIET (pirfenidone) 1350/20.000420	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Information:** Diagnosis of idiopathic pulmonary fibrosis or unclassifiable interstitial lung disease (ILD) supported by: Pulmonary function testing (PFTs) demonstrating reductions in forced vital capacity (FVC), diffusing capacity (DLCO), and distance walked on the six-minute walk test (6MWT) AND negative workup for rheumatic or connective tissue diseases (e.g. lupus, rheumatoid arthritis, sarcoidosis) and drug, environmental, or radiation-induced pulmonary fibrosis AND high resolution computed tomography (HRCT) of the chest showing a usual interstitial pneumonia (UIP) pattern (i.e. reticular opacities and areas of honeycombing limited to subpleural and basilar areas) OR surgical lung biopsy demonstrating pathological characteristics of IPF or probable IPF, documentation of recent liver function tests (LFTs) within one month prior to initiation demonstrating baseline liver function. Enrollee does not have a history of severe hepatic impairment (Child Pugh Class C).Continuation will be contingent upon documented clinical improvement (i.e. improvement in PFTs including FVC, exercise tolerance/6MWT, dyspnea, etc.) as well as documented safety monitoring including the following: Liver function testing completed monthly in the first 6 months after imitation, then every 3 months thereafter showing increases in ALT/AST less than 3x upper normal limit and bilirubin within normal limits. Esbriet/pirfenidone will not be approved as a re-challenge for enrollees on previous Esbriet/pirfenidone therapy with certain liver function abnormalities-If enrollee exhibits greater than 3 upper normal limit ALT and/or AST accompanied by symptoms or hyperbilirubinemia Esbriet/pirfenidone should be permanently discontinued per FDA-approved labeling and re-challenge with Esbriet/pirfenidone will not be considered for coverage. Continuation will be contingent upon documented clinical improvement (i.e. improvement in PFTs including FVC, exercise tolerance/6MWT, dyspnea, etc.) **Exclusions:** Enrollee is concurrently prescribed a strong (ie fluvoxamine) OR moderate (ie ciprofloxacin) inhibitor of CYP1A2. Enrollee has previously received a lung transplant **Age Restrictions:** 18 and older. **Prescriber Restrictions:** Pulmonologist. **Approvals:** Initial 3 months, continuation 6 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:** Indefinitely until plan enrollment ended.
EXKIVITY (mobocertinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** Indefinitely until plan enrollment ended.

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FABRAZYME (agalsidase) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** 12 months.
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
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
GATTEX (teduglutide) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.

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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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
GROWTH HORMONE 1350/20.000134 • *NORDITROPIN*	**Covered indications**: All Medically-Accepted Indications (FDA approved and from Part D. **Required Medical Info**: 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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
HIGH RISK MEDICATIONS **1350/20.000242** • *benztropine* • *carisoprodol* • *clomipramine* • *cyclobenzaprine* • *cyproheptadine tabs/syrup* • *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. **Required Medical Info:** 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). **Required Medical Info:** 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). **Required Medical Info:** 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 at least one immunosuppressant such as cortico-steroids, 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. Ulcerative colitis- Approve for those 5 years of age and older. **Approvals:** 12 months.
HYFTOR (sirolimus) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
icatibant 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and **compendia-supported)**. **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
Imatinib 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.

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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:** Indefinitely until plan enrollment ended.
IMMEDIATE RELEASE FENTANYL 1350/20.000281 • *fentanyl citrate buccal tabs* • *fentanyl lozenges*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Required Medical Info:** 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) 1350/20.000423	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Information:** Diagnosis of advanced Parkinson's disease, documented use of 2 of the 4 approaches to managing OFF episodes: altering carbidopa/levodopa therapy, doapmine agonists, COMT inhibitor, MAO-B inhibitor. Enrollee does not have a diagnosis of COPD, asthma or other chronic respiratory disease. Enrollee has FEV1 greater than 50%, and enrollee is currently being treated with carbidopa/levodopa. Maximum Levodopa daily dosing should not exceed 1,600mg including all formulations (oral and inhalation) FEV1 to FVC ratio over 60% when in an ON state. **Exclusions:** Use of a nonselective MAO inhibitor, severe dyskinesia, previous neurosurgical treatment for Parkinson's disease, active psychosis or anti-psychotic drug treatment, orthostatic hypotension **Prescriber Restrictions:** Neurologist **Approvals:** 6 months.
INCRELEX (mecasermin, recombinant) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
INGREZZA (valbenazine) 1350/20.000419	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Significant risk for suicidal or violent behavior or unstable psychiatric symptoms. Enrollee must not have dual therapy with other vesicular monamine transporter 2 (VMAT) inhibitors or concomitant use of a monoamine oxidase inhibitor (MAOI). **Age Restrictions:** 18 and older **Prescriber Restrictions:** Psychiatrist or neurologist **Approvals:** Initial approval 3 months. Renewal requests if policy criteria met 6 months. Must provide documentation of complete list of concurrent medications including strength and dosage regimen upon renewal.

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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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
KALYDECO (ivacaftor) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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KORLYM (mifepristone, RU486) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
KYNMOBI (apomorphine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
LAPATINIB 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
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:** Indefinitely until plan enrollment ended.
Lidocaine patches 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
LUMAKRAS (sotorasib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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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.
miglustat 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
MONJUVI (tafasitamab) 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.
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:** Indefinit**ely until plan enrollment ended.**
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:** Indefinit**ely until plan enrollment ended.**
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**: Indefinitely until plan enrollment ended.
NEXLETOL (bempedoic acid) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
NEXLIZET (bempedoic acid/ ezetimibe) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.

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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:** Indefinitely until plan enrollment ended.
nitisinone 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
NORTHERA (droxidopa) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
NUCALA (mepolizumab) 1350/20.000364	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** Acute bronchospasm or status asthmaticus **Required Medical Info:** Ages 6 and above: 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 150 cells/mcL within 6 weeks of starting therapy OR greater than 300 cells/mcL in the previous 12 months. 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). These standards will not be applicable to other FDA approved diagnoses such as chronic rhinosinusitis with nasal polyps, eosinophilic granulomatosis with polyangitis and hypereosinophilic syndrome. 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. Hypereosinophilic syndrome: 12 years and older, chronic rhinosinusitis with nasal polyps: 18 years and older. **Prescriber Restrictions:** Pulmonologist, allergist, immunologist, rheumatologist. hematologist, otolaryngologist **Approvals:** 6 months, continutation requires documentation of clinical improvement or sustained efficacy

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NUEDEXTA (dextromethorphan; quinidine) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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OFEV (nintedanib) 1350/20.000420	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Required Medical Information:** Diagnosis of idiopathic pulmonary fibrosis supported by: Pulmonary function testing (PFTs) demonstrating reductions in forced vital capacity (FVC), diffusing capacity (DLCO), and distance walked on six-minute walk test (6MWT) AND negative workup for rheumatic or connective tissue diseases and drug, environmental, or radiation-induced pulmonary fibrosis AND high resolution computed tomography (HRCT) of the chest showing a usual interstitial pneumonia (UIP) pattern OR surgical lung biopsy demonstrating pathological characteristics of IPF or probable IPF. Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype supported by- presence of fibrotic ILD as determined by high resolution computed tomography (HRCT) involving at least 10% of the lungs AND evidence of progression of fibrotic changes on HRCT in the previous 24 months AND PFTs demonstrating reductions in FVC of greater than 10% within the previous 24 months. Diagnosis of systemic sclerosis associated interstitial lung disease (SSc-ILD) supported by-presence of fibrotic ILD as determined by high resolution computed tomography (HRCT) involving at least 10% of the lungs AND skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints OR at least 2 of the following: Skin thickening of the fingers, Fingertip lesions, telangiectasia, Abnormal nailfold capillaries, Pulmonary arterial hypertension (PAH), Raynaud's phenomenon, Positive for SSc-related autoantibody antitopoisomerase I. For all diagnoses: documentation of recent liver function tests (LFTs) within one month prior to initiation demonstrating baseline liver function. Enrollee does not have a history of severe hepatic impairment (Child Pugh Class B-C). Ofev will not be approved as a re-challenge for enrollees on previous Ofev therapy with certain liver function abnormalities-If enrollee exhibits greater than 3 upper normal limit ALT and/or AST accompanied by symptoms or hyperbilirubinemia Ofev should be permanently discontinued per FDA-approved labeling and re-challenge with Ofev will not be considered for coverage. Continuation will be contingent upon documented clinical improvement (i.e. improvement in PFTs including FVC, exercise tolerance/6MWT, dyspnea, etc.) as well as documented safety monitoring including the following: LFTs completed monthly in the first 6 mo. after imitation, then every 3 mo. thereafter showing increases in ALT/AST less than 3x upper normal limit and bilirubin within normal limits. **Exclusions:** Enrollee has previously received a lung transplant **Age Restrictions:** 18 and older **Prescriber Restrictions:** Pulmonologist **Approvals:** Initial 3 months, continuation 6 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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
ORKAMBI (lumacaftor/ivacaftor) **1350/20.000278**	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
OTEZLA (apremilast) **1350/20.000278**	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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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:** Indefinitely until plan enrollment ended.
PHENYLBUTYRATE 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
PRALUENT (alirocumab) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals:** Indefinitely until plan enrollment ended.
PREVYMIS (letermovir) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** Indefinitely until plan enrollment ended.

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PROLIA (denosumab) 1350/20.000333	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Required Medical Info:** 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.
PROMACTA (eltrombopag olamine) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None. **Approvals:** Indefinitely until plan enrollment ended.
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. For sildenafil suspension, patient must have tried and failed, intolerance or contraindication to sildenafil citrate (PAH) tablets. **Approvals:** 12 months.

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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**: Indefinitely until plan enrollment ended.
Quinine sulfate 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
RELYVRIO (sodium phenylbutyrate/ taurursodiol) oral suspension, 1350.20.000467	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Required Medical Info:** Current use of riluzole or evidence of treatment failure or intolerance of riluzole **Age Restrictions:** 18 or older **Prescriber Restrictions:** Must be prescribed by a neurologist who specializes in motor neuron disease **Exclusions:** Abnormal liver function defined as AST and/or ALT greater than 3 times UL of normal. Renal insufficiency defined by eGFR less than 60 ml per min per 1.73m2. History of cholecystectomy, biliary disease, pancreatic disease or intestinal disorders **Approvals**: 6 months- Continuation Criteria: Documentation to support ongoing therapy including provider attestation that the patient is receiving some benefit
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) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None. **Approvals**: Indefinitely until plan enrollment ended.

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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. HIV patients stable on zidovudine therapy- 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**: Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
REZUROCK (belumosudil) **1350/20.000278** *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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.

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RINVOQ (upadacitinib) 1350/20.000278	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
SAPROPTERIN 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals:** Indefinit**ely until plan enrollment ended.**
SCEMBLIX (asciminib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.

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SIGNIFOR (pasireotide) **1350/20.000278**	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
SIRTURO (bedaquiline) **1350/20.000278**	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
SKYRIZI (risankizumab rzaa) **1350/20.000278**	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
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.

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STELARA (ustekinumab) **1350/20.000366**	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Info**: 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 and Psoriatic Arthritis- 6 years of age and older, Ulcerative Colitis and Crohn's- 18 years 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**: Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
SYMDEKO (tezacaftor-ivacaftor) **1350/20.000278**	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions:** None **Approvals**: Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.

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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:** Indefinit**ely until plan enrollment ended.**
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:** Indefinit**ely until plan enrollment ended.**
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
TASIGNA (nilotinib) 1350/20.000181 *PA applies to new starts only*	**Covered Indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Required Medical Information:** Adults with Ph+CML in CP or accelerated phase: resistant to or intolerant to prior therapy with imatinib. Peds with Ph+CML in CP: resistant to or intolerant to prior tyrosinekinase inhibitor (TKI) therapy. Adult and pediatric patients with newly diagnoses Philadelphia chromosome positive CML- no prior therapy required. **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) and Chronic Phase (CP) Ph+CML resistant/intolerant to prior therapy that included imatinib: Approved for those 18 years of age or older. Ph+CML-CP and CML-AP 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:** Indefinitely until plan enrollment ended.
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.

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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:** Indefinitely until plan enrollment ended.
TETRABENAZINE 1350/20.000419	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Significant risk for suicidal or violent behavior or unstable psychiatric symptoms. Enrollee must not have dual therapy with other vesicular monamine transporter 2 (VMAT) inhibitors or concomitant use of a monoamine oxidase inhibitor (MAOI). **Age Restrictions:** 18 and older **Prescriber Restrictions:** Psychiatrist or Neurologist **Approvals:** Initial approvals 3 months. Renewal requests if policy criteria met 6 months. Must provide documentation of complete list of concurrent medications including strength and dosage regimen upon renewal.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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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TREMFYA (guselkumab) **1350/20.000456**	**Covered indications:** All FDA-approved indications and some Medically-Accepted Indications. **Required Medical Info:** **Criteria for initial approval require ALL of the following:** 1. Patient has an FDA labeled indication for the requested agent AND 2. ONE of the following: A. There is evidence of a claim that the patient has been treated with the requested agent within the past 90 days OR B. Prescriber states the patient has been treated with the requested agent AND is at risk if therapy is changed OR C. Patient's medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patient's medication history indicates use of ONE formulary conventional prerequisite agent for the requested indication OR E. Patient has an intolerance or hypersensitivity to at least ONE formulary conventional prerequisite agent for the requested indication OR F. Patient has an FDA labeled contraindication to at least ONE formulary conventional prerequisite agent for the requested indication AND 3. Patient will NOT be using the requested agent in combination with another biologic immunomodulator **Criteria for renewal approval require ALL of the following:** 1. Patient has been previously approved for the requested agent through the plan's Prior Authorization criteria AND 2. Patient has an FDA labeled indication for the requested agent AND 3. Patient has had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency) AND 4. Patient will NOT be using the requested agent in combination with another biologic immunomodulator **Exclusions:** FDA labeled contraindications to the requested agent **Other Criteria:** Use of ONE conventional prerequisite agent is required for diagnoses of psoriatic arthritis or plaque psoriasis. Formulary conventional agents for psoriatic arthritis include cyclosporine, leflunomide, methotrexate, or sulfasalazine. Formulary conventional topical or systemic antipsoriatic agents include acitretin, calcipotriene, methotrexate, tazarotene, or topical corticosteroids. **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:** Indefinitely until plan enrollment ended.
TRUSELTIQ (infigratinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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 **Required Medical Info:** 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:** None **Approvals:** Initial- 3 months, renewals-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:** Indefinitely until plan enrollment ended.
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.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
VIJOICE (alpelisib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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VONJO (pacritinib) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
voriconazole 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
WELIREG (belzutifan) 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.
XELJANZ (tofacitinib) 1350/20.000278	**Covered indications**: All FDA-approved indications not otherwise excluded from Part D. **Exclusions**: None **Approvals:** Indefinitely until plan enrollment ended.
XERMELO (telotristat ethyl) 1350/20.000278	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals:** Indefinitely until plan enrollment ended.

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XGEVA (denosumab) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
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. Nasal Polyps: enrollee has received treatment with an intranasal corticosteroid for at least 8 weeks prior to requesting Xolair AND enrollee has at least 2 of the following 3 symptoms: nasal congestion or obstruction, loss of smell, nasal discharge. 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. Nasal Polyps: 18 years and 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**: Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.

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XTANDI (enzalutamide) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
XYREM (sodium oxybate) 1350/20.000278	**Covered indications:** All FDA-approved indications not otherwise excluded from Part D **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
ZARXIO (filgrastim) 1350/20.000278	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** Treatment of acute afebrile neutropenia. **Approvals:** 3 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:** Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
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**: Indefinitely until plan enrollment ended.
ZTALMY (ganaxolone) suspension 1350/20.000278 *PA applies to new starts only*	**Covered indications**: All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions**: None **Approvals**: Indefinitely until plan enrollment ended.
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:** Indefinitely until plan enrollment ended.

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ZYKADIA (ceritinib) capsules/tabs *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.
ZYPREXA RELPREVV (olanzapine) 1350/20.000278 *PA applies to new starts only*	**Covered indications:** All Medically-Accepted Indications (FDA approved and compendia-supported). **Exclusions:** None **Approvals:** Indefinitely until plan enrollment ended.