CDPHP® Medicare Advantage
2024 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.

ABIRATERONE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ACNE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** Cosmetic Use **COVERAGE DURATION:** 12 months **OTHER 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. **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ACTIMMUNE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

AIMOVIG **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** 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: antiepileptic 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 **COVERAGE DURATION:** Initial approval 3 months, continuation 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
AJOVY **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** 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: antiepileptic 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 **COVERAGE DURATION:** Initial approval 3 months, continuation 12 months **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ALDURAZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
AKEEGA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ALECENSA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ALPHA1-PROTEINASE INHIBITOR **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ALUNBRIG **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ARANESP **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ARCALYST **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

AURYXIA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: For the treatment of iron deficiency anemia in patients with chronic kidney disease not on dialysis, patients with iron overload syndrome (hemochromatosis)
REQUIRED MEDICAL INFORMATION: The requested drug will be covered when the following criteria are met: 1) The enrollee is 18 years of age or older AND 2) the enrollee has a diagnosis of hyperphosphatemia in Chronic Kidney Disease on dialysis
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

AUSTEDO

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: 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 RESTRICTION: 18 years and older
PRESCRIBER RESTRICTION: Psychiatrist or neurologist
COVERAGE DURATION: Initial approval - 3 months. Renewal requests - 6 months after patient is evaluated and does not have any exclusion criteria as listed.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

AVASTIN

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

AYVAKIT

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

BALVERSA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BENLYSTA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BENZODIAZEPINES **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** A. If for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to one formulary drug indicated for anxiety including, but not limited to buspirone, duloxetine, escitalopram , venlafaxine or paroxetine AND B. If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. **COVERAGE DURATION:** Alcohol Withdrwl-1mo, Anxiety-6mo, Muscle Spasms-reflex 6mo,motor neuron disorder-Seizures-Plan Year **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BERINERT **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BESREMI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

BEXAROTENE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BOSULIF **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BRAFTOVI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BRIVIACT **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BRONCHITOL **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

BRUKINSA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
BYLVAY **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CABOMETYX **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CALQUENCE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CAMZYOS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

CAPRELSA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CARGLUMIC ACID **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CERDELGA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CEREZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CLOBAZAM **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

COMETRIQ **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
COPIKTRA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

COSENTYX

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: FDA labeled contraindications to the requested agent
REQUIRED MEDICAL INFORMATION: 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

COVERAGE DURATION: 12 months
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
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

COTELLIC

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

CYSTAGON **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
CYSTEAMINE OPHTHALMIC **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
DAURISMO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
DAYBUE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
DEFERASIROX **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

DEFERIPRONE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
DHE NASAL **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
DIACOMIT **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

DOPTELET

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: Enrollees undergoing procedures that have a low risk of bleeding associated. Enrollees undergoing procedures including laparotomy, thoracotomy, open-heart surgery, crainiotomy 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
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 thrombocytopenia- 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 spenectomy 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
PRESCRIBER RESTRICTIONS: Prescribed by or in consultation with a hematologist, hepatologist, or surgeon
COVERAGE DURATION: 12 months
OTHER CRITERIA: 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.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

DROXIDOPA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

DUPIXENT

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody
REQUIRED MEDICAL INFORMATION: Atopic Dermatitis: The enrollee must have a diagnosis of moderate-to-severe chronic atopic dermatitis and have an inadequate response, intolerance, or contraindication with one medium to very high potency topical corticosteroid OR atopic dermatitis affecting only the face, eyelids, skin folds, and/or genitalia and have an inadequate response, intolerance, or contraindication with one topical calcineurin inhibitor (e.g., tacrolimus ointment). Asthma: The enrollee must have a diagnosis of moderate to severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma and Dupixent must be requested to be used as add-on maintenance treatment with standard of care asthma drugs (e.g., inhaled corticosteroids, leukotriene modifiers, long-acting beta agonists, long-acting muscarinic antagonists). For renewal requests Dupixent must continue to be used with standard of care asthma drugs. Chronic rhinosinusitis with nasal polyposis: The enrollee must have a diagnosis of chronic rhinosinusitis with nasal polyposis and have an inadequate response, intolerance, or contraindication with a systemic corticosteroid and have an inadequate response, intolerance, or contraindication with an intranasal corticosteroid OR have had prior surgery for nasal polyps. Eosinophilic esophagitis: The enrollee must have a diagnosis of eosinophilic esophagitis confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field and not have a secondary cause of eosinophilic esophagitis, and have received at least 8 weeks of treatment with a prescription strength proton pump inhibitor. Prurigo nodularis: The enrollee must have a diagnosis of prurigo nodularis and have greater than or equal to 20 nodular lesions and AND have tried at least 1 medium to very high potency prescription topical corticosteroid.
AGE RESTRICTIONS: None
PRESCRIBER RESTRICTIONS: Atopic Dermatitis/prurigo nodularis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist. Esophagitis-prescribed by or in consultation with an allergist or gastroenterologist.
COVERAGE DURATION: Initial 6mo, cont, 12mo. For all indic: Continuation contingent upon documented clinical improvement
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EGRIFTA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EMGALITY

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: If used for prevention, the following criteria need to be 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: antiepileptic 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.
2) Patient has a diagnosis of episodic cluster headache AND BOTH of the following:
a. Patient has had at least 5 cluster headache attacks AND
b. Patient has had at least two cluster periods lasting 7 days to one year and separated by pain-free remission periods of 3 months or more
COVERAGE DURATION: Initial approval 3 months, continuation 12 months
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA, CDPHP 5T (24471) MAPD

EMPAVELI

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ENBREL

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: 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
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ENDARI

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
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 inconsultation with SCD specialist or a hematologist
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ENSPRYNG

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EPCLUSA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
AGE RESTRICTIONS: 3 and older
PRESCRIBER RESTRICTIONS: Gastroenterologist, Hepatologist, HIV or infectious disease specialist
COVERAGE DURATION: Approval duration will be applied consistently 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.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EPIDIOLEX

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EPOETIN ALFA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: 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.
REQUIRED MEDICAL INFORMATION: 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 levles 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.
COVERAGE DURATION: Initial/dose chg 12 wk, Stable-CRF-24 wk, anemia of ca-12 wk, zidov-treated pts with HIV inf-12 wk, reduction of RBC transfusion-6wk
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ERIVEDGE

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ERLEADA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ERLOTINIB

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

EVEROLIMUS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
EXKIVITY **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
FABRAZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
FENTANYL PATCH **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** Current utilization of medication assisted therapy to treat opioid use disorder or alcohol use disorder **REQUIRED MEDICAL INFORMATION:** 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. **COVERAGE DURATION:** Pain with cancer, terminal conditions, hospice/palliative care= 12 months.Non- Cancer Pain= 6 months **OTHER CRITERIA:** 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. **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

FINTEPLA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
FOTIVDA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
FRUZAQLA **PA INDICATION:** All FDA- Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
FYCOMPA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
GATTEX **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

GAVRETO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
GEFITINIB **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
GILOTRIF **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
GLEOSTINE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
GLP-1 **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** Use for weight loss alone **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

GROWTH HORMONE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** Severe respiratory impairment or sleep apnea (Prader-Willi syndrome) **REQUIRED MEDICAL INFORMATION:** Growth hormone stimulation tests. Children- presenting height must be below 5th percentile. Must be radiographically- documented evidence of delayed bone age. **PRESCRIBER RESTRICTION:** Endocrinologist, HIV or infectious disease specialist **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HAEGARDA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HARVONI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **PRESCRIBER RESTRICTION:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **COVERAGE DURATION:** Approval duration will be applied consistently 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. **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HERCEPTIN **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

HERCEPTIN HYLECTA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HERZUMA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HETLIOZ **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
HRM EDITS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

HRM HYPNOTICS

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: 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.
REQUIRED MEDICAL INFORMATION: This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. PA will only be required after a cumulative 90 day supply is filled within the year
AGE RESTRICTION: PA applies to members 65 years and older
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

HUMIRA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: 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 corticosteroids, azathioprine or 6-mercaptopurine.
AGE RESTRICTION: Crohn's- Approve for those 6 years of age and older, Hidradenitis suppurativa-Approve for those 12 years of age and older, Juvenile Idiopathis Arthritis and Uveitis- Approve for those 2 years of age and older. Ulcerative Colitis- Approve for those 5 years of age and older
PRESCRIBER RESTRICTION: Rheumatologist, Dermatologist, Gastroenterologist or Ophthamologist
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

HYFTOR

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

IBRANCE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ICATIBANT **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ICLUSIG **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
IDHIFA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
IMATINIB **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

IMBRUVICA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CCY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
IMMEDIATE-RELEASE FENTANYL **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** Must be used for the management of breakthrough pain in patients with cancer, who are already receiving, and who are tolerant to, around the clock opioid therapy for their underlying persistent pain. **PRESCRIBER RESTRICTION:** Oncologist, hematologist, pain management or palliative care **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
INBRIJA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** Use of a a nonselective MAO inhibitor, severe dyskinesia, previosus neurosurgical treatment for Parkinsons' disease, active psychosis or antipsychotic drug treatment, orthostatic hypotension **REQUIRED MEDICAL INFORMATION:** Diagnosis of advanced Parkinsons' 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 FEV1 to FVC ratio over 60% when in an ON state **PRESCRIBER RESTRICTION:** Neurologist **COVERAGE DURATION:** 6 months **OTHER CRITERIA:** Enrollee is currently being treated with carbidopa/levodopa. Maximum Levodopa daily dosing should not exceed 1,600mg including all formulations (oral and inhalation) **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
INCRELEX **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

INGREZZA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** 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). (within 14 days of discontinuing MAOI therapy) **AGE RESTRICTION:** 18 years and older **PRESCRIBER RESTRICTION:** Psychiatrist or neurologist **COVERAGE DURATION:** Initial approval 3 months. Renewal requests if policy criteria met 6 months **OTHER CRITERIA:** Must provide documentation of complete list of concurrent medications including strength and dosage regimen upon renewal **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
INLYTA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
INQOVI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
INREBIC **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

JAKAFI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
JAYPIRCA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
JOENJA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
JUXTAPID **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
JYNARQUE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

KALBITOR **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KALYDECO **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KANJINTI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KEVZARA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KEYTRUDA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

KINERET **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** For rheumatoid arthritis: Patients medication history indicates use of at least TWO preferred biological immunomodulator agents (Enbrel, Humira, Rinvoq, Xeljanz) for the requested indication OR patient has an intolerance or hypersensitivity to at least TWO preferred biological immunomodulator agents (Enbrel, Humira, Rinvoq, Xeljanz) for the requested indication OR patient has an FDA labeled contraindication to at least TWO preferred biological immunomodulator agents (Enbrel, Humira, Rinvoq, Xeljanz) for the requested indication **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KISQALI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KORLYM **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
KOSELUGO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

KRAZATI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LAPATINIB **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LENVIMA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LIDOCAINE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LIVMARLI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

LIVTENCITY

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

LONG ACTING OPIATES

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: Current utilization of medication assisted therapy to treat opioid use disorder or alcohol use disorder
REQUIRED MEDICAL INFORMATION: 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.
COVERAGE DURATION: Pain with cancer, terminal conditions, hospice/palliative care= 12 months. Non- Cancer Pain= 6 months
OTHER CRITERIA: 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.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

LONSURF

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

LORBRENA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LUMAKRAS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LUMIZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LUPKYNIS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
LYNPARZA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

LYTGOBI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MAVYRET **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **AGE RESTRICTION:** 3 years and older **PRESCRIBER RESTRICTION:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **COVERAGE DURATION:** Approval duration will be applied consistently with AASLD-IDSA guidance **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MEKINIST **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MEKTOVI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MEMANTINE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **AGE RESTRICTION:** PA applies to members under 30 years of age only **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

MIGLUSTAT **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MONJUVI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MULPLETA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
MVASI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NAGLAZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

NATPARA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NERLYNX **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NEXLETOL **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NEXLIZET **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NEXVIAZYME **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

NINLARO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NITISINONE **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NOCDURNA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NUBEQA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

NUCALA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** Acute bronchospasm or status asthmaticus **REQUIRED MEDICAL INFORMATION:** 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 **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 **COVERAGE DURATION:** 6 months, continutation requires documentation of clinical improvement or sustained efficacy **OTHER CRITERIA:** The enrollee must not have had a parasatic infection within the last 6 months. Approval for severe asthma will be contingent on the continued use of standard of care for asthma (inhaled corticosteroids and additional controlled medications such as long acting beta agonists) **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NUEDEXTA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
NUPLAZID **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

NURTEC

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: If used for prevention the following criteria need to be 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: antiepileptic 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. If used for acute treatment, the following criteria need to be met: 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 2 different formulary triptan agents at maximally indicated dose unless contraindicated
COVERAGE DURATION: Initial approval 3 months, continuation 12 months
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA, CDPHP 5T (24471) MAPD

ODOMZO

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

OFEV

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
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), RaynaudÂ¿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).
AGE RESTRICTIONS: 18 and over
PRESCRIBER RESTRICTIONS: Pulmonologist
COVERAGE DURATION: Initial- 3 months, continuation 6 months
OTHER CRITERIA: 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.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

OGIVRI

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

OJJAARA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ONTRUZANT **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ONUREG **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
OPFOLDA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ORGOVYX **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ORIAHNN **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ORILISSA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ORKAMBI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ORSERDU **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
OTEZLA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

OXERVATE **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **AGE RESTRICTIONS:** Ages 2 and older **PRESCRIBER RESTRICTIONS:** Ophthalmologist **COVERAGE DURATION:** 8 weeks **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PEGASYS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PEMAZYRE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PHENYLBUTYRATE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PHESGO **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PIQRAY

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PIRFENIDONE

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: Enrollee is concurrently prescribed a strong (ie fluvoxamine) OR moderate (ie ciprofloxacin) inhibitor of CYP1A2. Enrollee has previously received a lung transplant
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.
AGE RESTRICTIONS: 18 and over
PRESCRIBER RESTRICTIONS: Pulmonologist
COVERAGE DURATION: Initial- 3 months, continuation 6 months
OTHER CRITERIA: 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.)
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

POMALYST

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

POMBILITI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PRALUENT **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PRETOMANID **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
PREVYMIS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PROLIA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: 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.
AGE RESTRICTIONS: Approved for those 18 years of age or older
COVERAGE DURATION: 12 months
OTHER CRITERIA: Should be administered by a healthcare professional. Dosing is a subcutaneous injection of 60mg every 6 months.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PROMACTA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PULMONARY ARTERIAL HYPERTENSION

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
PRESCRIBER RESTRICTIONS: Cardiologist, Pulmonologist
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

PYRUKYND **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
QINLOCK **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
QUININE SULFATE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
QULIPTA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** 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: antiepileptic 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 **COVERAGE DURATION:** Initial approval 3 months, continuation 12 months **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RAVICTI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

RELYVRIO

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: 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
REQUIRED MEDICAL INFORMATION: Current use of riluzole or evidence of treatment failure or intolerance of riluzole
AGE RESTRICTION: 18 years or older
PRESCRIBER RESTRICTION: Must be prescribed by a neurologist who specializes in motor neuron disease
COVERAGE DURATION: 6 months
OTHER CRITERIA: Continuation criteria- documentation to support ongoing therapy including provider attestation that the patient is receiving some benefit
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

REMICADE

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

RENFLEXIS

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

REPATHA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

RETEVMO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
REVLIMID **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
REYVOW **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** 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 2 different formulary triptan agents at maximally indicated dose unless contraindicated **COVERAGE DURATION:** Initial 3 months, renewals 12 months **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
REZLIDHIA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
REZUROCK **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

RIABNI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RINVOQ **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RITUXAN **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RITUXAN HYCELA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ROZLYTREK **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

RUBRACA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RUFINAMIDE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RUXIENCE **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RUZURGI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
RYDAPT **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

SAPROPTERIN **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SCEMBLIX **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SIGNIFOR **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SIRTURO **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SKYCLARYS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

SKYRIZI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SOHONOS **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SOLIRIS **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SORAFENIB **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SPRYCEL **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** 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 **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

STELARA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: 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 Crohns 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 or older, Psoriatic Arthritis 6 years or older, Ulcerative Colitis or Crohn's 18 or older
PRESCRIBER RESTRICTIONS: Gastroenterologist, Rheumatologist or Dermatologist
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

STIVARGA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

STRENSIQ

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

SUCRAID

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

SUNITINIB **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SYMDEKO **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SYMPAZAN **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
SYNRIBO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TABRECTA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TAFAMIDIS **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TAFINLAR **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TAGRISSO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TAKHZYRO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TALZENNA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TARPEYO

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TASIGNA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
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
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TAZVERIK

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TECENTRIQ

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TEPMETKO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TETRABENAZINE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** 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). (within 14 days of discontinuing MAOI therapy) **AGE RESTRICTIONS:** 18 years and older **PRESCRIBER RESTRICTIONS:** Psychiatrist or neurologist **COVERAGE DURATION:** Initial approval 3 months. Renewal requests if policy criteria met 6 months **OTHER CRITERIA:** Must provide documentation of complete list of concurrent medications including strength and dosage regimen upon renewal **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
THALOMID **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TIBSOVO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TIOPRONIN **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TOLVAPTAN

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TRAZIMERA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: 12 months
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TREMFYA

PA INDICATION: All FDA-Approved Indications
EXCLUSION CRITERIA: FDA labeled contraindications to the requested agent
REQUIRED MEDICAL INFORMATION: 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. Patients medication history indicates use of another biologic immunomodulator agent for the same FDA labeled indication OR D. Patients 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 plans 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
COVERAGE DURATION: 12 months
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
FORMULARIES: CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TRIKAFTA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TRUQAP **PA INDICATION:** All FDA- Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TRUSELTIQ **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TRUXIMA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TUKYSA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

TURALIO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
TYSABRI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
UBRELVY **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **REQUIRED MEDICAL INFORMATION:** 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 2 different formulary triptan agents at maximally indicated dose unless contraindicated **COVERAGE DURATION:** Initial 3 months, renewals 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VALCHLOR **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VANFLYTA **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

VELCADE **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VENCLEXTA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VERZENIO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VIGABATRIN **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VIJOICE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

VITRAKVI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VIZIMPRO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VONJO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VORICONAZOLE **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VOSEVI **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **AGE RESTRICTIONS:** 18 years and older **PRESCRIBER RESTRICTIONS:** Gastroenterologist, Hepatologist, HIV or infectious disease specialist **COVERAGE DURATION:** Approval duration will be applied consistently with AASLD-IDSA guidance **OTHER CRITERIA:** Omeprazole 20mg can be administered with Vosevi. Use with other proton pump inhibitors has not been studied **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

VOTRIENT **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
VOWST **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
WAKIX **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
WELIREG **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XALKORI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

XDEMVY **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 3 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XELJANZ **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XERMELO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XGEVA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

XOLAIR

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
REQUIRED MEDICAL INFORMATION: 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
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
COVERAGE DURATION: 12 months
OTHER CRITERIA: 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.
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

XOSPATA

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

XPOVIO

PA INDICATION: All Medically-Accepted Indications
EXCLUSION CRITERIA: None
COVERAGE DURATION: Indefinitely until plan enrollment ended
FORMULARIES: CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

XTANDI **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XYREM **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
XYWAV **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZARXIO **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** Treatment of acute afebrile neutropenia. **COVERAGE DURATION:** 3 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZEJULA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ZELBORAF **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZIRABEV **PA INDICATION:** All FDA-Approved Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** 12 months **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZOLINZA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZTALMY **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZYDELIG **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA

ZYKADIA **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA
ZYPREXA RELPREVV **PA INDICATION:** All Medically-Accepted Indications **EXCLUSION CRITERIA:** None **COVERAGE DURATION:** Indefinitely until plan enrollment ended **FORMULARIES:** CY2024 CDPHP 5T (24471) MAPD, CY2024 CDPHP 6T (24473) MEDICARE ADVANTAGE EXTRA