ABILIFY ASIMTUFII(GHP)

MEDICATION(S)
ABILIFY ASIMTUFII

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA or BIPOLAR I DISORDER AS MONOTHERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF FAILURE ON OR INTOLERANCE TO ORAL EQUIVALENT OF REQUESTED INJECTABLE THERAPY.

ABILIFY MYCITE(GHP)

MEDICATION(S)
ABILIFY MYCITE, ABILIFY MYCITE MAINTENANCE KIT, ABILIFY MYCITE STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of schizophrenia OR diagnosis of acute treatment of mania and mixed episodes or maintenance treatment of Bipolar I disorder as either monotherapy or as adjunct to lithium or valproate OR diagnosis of use as adjunctive treatment of major depressive disorder.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THE NEED TO MONITOR DRUG INGESTION AND DOCUMENTATION OF ACCESS TO A COMPATIBLE SMART PHONE. FOR SCHIZOPHRENIA AND BIPOLAR I DISORDER: DOCUMENTATION OF REASON WHY ARIPIPRAZOLE ORAL TABLETS CANNOT BE USED. FOR ADJUNCTIVE TREATMENT OF MAJOR DEPRESSIVE DISORDER: DOCUMENTATION OF USE AS ADJUNCTIVE THERAPY AND DOCUMENTATION OF REASON WHY ARIPIPRAZOLE ORAL TABLETS CANNOT BE USED.

ABRAXANE(GHP)

MEDICATION(S)
ABRAXANE, PACLITAXEL PROTEIN-BOUND PART

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF BREAST CANCER OR DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) OR DIAGNOSIS OF METASTATIC ADENOCARCINOMA OF THE PANCREAS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR BREAST CANCER: DOCUMENTATION OF FAILURE ON COMBINATION CHEMOTHERAPY FOR METASTATIC DISEASE OR RELAPSE WITHIN 6 MONTHS OF ADJUVANT CHEMOTHERAPY AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ANTHRACYCLINE AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO STANDARD PACLITAXEL THERAPY. FOR NSCLC: DOCUMENTATION OF ABRAXANE USED AS FIRST-LINE TREATMENT IN COMBINATION WITH CARBOPLATIN WHO ARE NOT CANDIDATES FOR CURATIVE SURGERY OR RADIATION THERAPY. FOR ADENOCARCINOMA OF PANCREAS: DOCUMENTATION OF USE IN COMBINATION WITH GEMCITABINE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED

DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ACTEMRA SUBQ(GHP)

MEDICATION(S)
ACTEMRA 162 MG/0.9ML SOLN PRSYR, ACTEMRA ACTPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. DX OF GIANT CELL ARTERITIS. DX OF SYSTEMIC OR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. DX OF SYSTEMIC SCLEROSIS ACCORDING TO THE AMERICAN COLLEGE OF RHEUMATOLOGY (ACR) AND EUROPEAN LEAGUE AGAINST RHEUMATISM (EULAR).

AGE RESTRICTION
FOR GIANT CELL ARTERITIS AND SSC-ILD: 18 YEARS OF AGE OR OLDER. FOR RA AND SJIA/PJIA: MUST BE 2 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (HUMIRA, ENBREL, RINVOQ, XELJANZ). FOR GIANT CELL ARTERITIS, DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH ORAL GLUCOCORTICOIDS. FOR PJIA: FAILURE ON, CONTRAINDICATION TO OR INTOLERANCE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA.

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ACTEMRA(GHP)

MEDICATION(S)
ACTEMRA 200 MG/10ML SOLUTION, ACTEMRA 400 MG/20ML SOLUTION, ACTEMRA 80 MG/4ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. DX OF ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA) AND PRESCRIPTION WRITTEN FOR IV FORMULATION. DX OF ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PRESCRIPTION WRITTEN FOR IV FORMULATION. DX OF CHIMERIC ANTIGEN RECEPTOR (CAR) T CELL-INDUCED SEVERE OR LIFE-THREATENING CYTOKINE RELEASE SYNDROME. DX OF GIANT CELL ARTERITIS AND PRESCRIPTION WRITTEN FOR IV FORMULATION.

AGE RESTRICTION
FOR JIA AND CRS: MUST BE 2 YEARS OF AGE OR OLDER. FOR RA AND GCA: MUST BE 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR

CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (HUMIRA, ENBREL, RINVOQ, XELJANZ). FOR PJIA: FAILURE ON, CONTRAINDICATION TO OR INTOLERANCE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA. FOR GCA: DOCUMENTATION OF USE IN COMBINATION WITH ORAL GLUCOCORTICOIDS. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ACTIQ(GHP)

MEDICATION(S)
FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG LOZ HANDLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE TO MANAGE BREAKTHROUGH CANCER PAIN IN PATIENTS WITH CANCER

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
CONCOMITANT MORPHINE 60 MG/DAY OR MORE, TRANSDERMAL FENTANYL 25 MCG/H, OXYCODONE 30 MG/DAY, ORAL HYDROMORPHONE 8 MG/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR 1 WEEK OR LONGER.

ADAKVEO(GHP)

MEDICATION(S)
ADAKVEO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF SICKLE CELL DISEASE.

AGE RESTRICTION
MUST BE 16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF NUMBER OF VASOOCCLUSIVE CRISES IN THE PREVIOUS 12 MONTHS. DOCUMENTATION OF INTOLERANCE TO, CONTRAINDICATION OR THERAPEUTIC FAILURE ON 3 MONTH TRIAL OF HYDROXYUREA AND ENDARI. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED OR SUSTAINED IMPROVEMENT IN THE ACUTE COMPLICATIONS OF SICKLE CELL DISEASE (I.E., DECREASE IN VASOOCCLUSIVE CRISES, HOSPITALIZATIONS, AND NUMBER OF ACUTE CHEST SYNDROME (ACS) OCCURRENCES).

ADALIMUMAB(GHP)

MEDICATION(S)
ADALIMUMAB-FKJP, HADLIMA, HADLIMA PUSHTOUCH, YUSIMRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ADULT RA - DX OF RA MADE IN ACCORDANCE WITH THE ACR CRITERIA. JIA - DX OF MODERATE TO SEVERE JIA. PSORIATIC ARTHRITIS - DX OF MODERATE TO SEVERE PSA AND ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS. DIAGNOSIS OF PERIPHERAL PSA. DIAGNOSIS OF AXIAL PSA. PLAQUE PSORIASIS - DX OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. CROHN'S -DOCUMENTATION OF MODERATE OR HIGH RISK PATIENT OR A DX OF CROHNS DISEASE WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE, AZATHIOPRINE, CORTICOSTEROIDS OR METHOTREXATE. ANKYLOSING SPONDYLITIS - DX OF A.S. AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 2 FORMULARY NSAIDS. ULCERATIVE COLITIS - DX OF MODERATE TO SEVERE UC WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE, AZATHIOPRINE, CORTICOSTEROIDS OR AMINOSALICYLATES (SUCH AS BUT NOT LIMITED TO MESALAMINE, OLSALAZINE, OR SULFASALAZINE). FOR HIDRADENITIS SUPPURATIVA (HS)-DX OF MODERATE TO SEVERE HS, DEFINED AS STAGE II OR III ON THE HURLEY STAGING SYSTEM AND DOCUMENTATION OF AT LEAST 3 ABSCESSES OR INFLAMMATORY NODULES. UVEITIS - DX OF NON-INFECTIOUS ITERMEDIATE, POSTERIOR OR PANUVEITIS.

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS FOR: PSORIASIS, PSA, RA, AND ANKYLOSING SPONDYLITIS.

PRESCRIBER RESTRICTION

RHEUMATOLOGIST, GASTROENTEROLOGIST, DERMATOLOGIST OR OPHTHALMOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE DISEASE MODIFYING ANTI-RHEUMATIC DRUG (DMARD), SUCH AS BUT NOT LIMITED TO METHOTREXATE, LEFLUNOMIDE OR SULFASALAZINE. FOR JIA: THERAPEUTIC FALIURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY NSAID AND ONE OF THE FOLLOWING DMARDS: LEFLUNOMIDE OR METHOTREXATE. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TWO FORMULARY NSAIDS. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE, CYCLOSPORINE OR PHOTOTHERAPY. FOR UVEITIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE LOCAL OR SYSTEMIC CORTICOSTEROID AND ONE SYSTEMIC THERAPY, SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE. FOR UC: IF REQUEST IS FOR WEEKLY DOSING ONE OF THE FOLLOWING: INADEQUATE DRUG TROUGH LEVELS TO SUPPORT WEEKLY DOSING PER AGA GUIDELINES OR DOCUMENTATION THAT WEEKLY DOSING WAS INITIATED PRIOR TO THE MEMBER TURNING 18 YEARS AND THE MEMBER IS WELL-CONTROLLED ON THIS DOSE OR MEMBER IS LESS THAN 18 YEARS OF AGE AND RECEIVING AN APPROPRIATE DOSE BASED ON BODY WEIGHT. FOR CONTINUED THERAPY MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ADASUVE(GHP)

MEDICATION(S)
ADASUVE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR THE ACUTE TREATMENT OF AGITATION ASSOCIATED WITH SCHIZOPHRENIA OR BIPOLAR I DISORDER. DOCUMENTATION THAT THERE IS NO CURRENT DIAGNOSIS OR HISTORY OF ASTHMA, COPD, OR OTHER LUNG DISEASE ASSOCIATED WITH BRONCHOSPASM.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE IMMEDIATE RELEASE FORMULARY ANTIPSYCHOTIC INCLUDING BUT NOT LIMITED TO ARIPIPRAZOLE, CHLORPROMAZINE, HALOPERIDOL, OLANZAPINE, QUETIAPINE, RISPERIDONE, OR ZIPRASIDONE. MUST BE ADMINISTERED IN AN ENROLLED HEALTHCARE FACILITY WITH IMMEDIATE, ON-SITE RESOURCES TO MANAGE BRONCHOSPASM AND/OR RESPIRATORY DISTRESS.

ADBRY(GHP)

MEDICATION(S)
ADBRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF FAILURE ON EITHER DAILY TREATMENT WITH AT LEAST MEDIUM POTENCY TOPICAL CORTICOSTEROID OR TOPICAL CALCINEURIN INHIBITOR (I.E. TACROLIMUS) IF TOPICAL CORTICOSTEROIDS ARE NOT ADVISABLE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ADCETRIS(GHP)

MEDICATION(S)
ADCETRIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CLASSICAL HODGKIN LYMPHOMA (CHL) AND DOCUMENTATION OF FAILURE OF AUTOLOGOUS HEMATOPOIETIC STEM CELL TRANSPLANT OR FAILURE OF AT LEAST 2 MULTI-AGENT CHEMOTHERAPY REGIMENS IN THOSE WHO ARE NOT CANDIDATES FOR AUTO-HSCT OR DOCUMENTATATION OF USE AS CONSOLIDATION TREATMENT FOLLOWING AUTO-HSCT IN PATIENTS WITH HIGH RISK OR RELAPSE OR PROGRESSION POST-AUTO-HSCT. DX OF PREVIOUSLY UNTREATED, HIGH RISK CHL IN PEDIATRIC PATIENTS AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION W/ DOXORUBICIN, VINCRISTINE, ETOPOSIDE, PREDNISONE, AND CYCLOPHOSPHAMIDE. DX OF SYSTEMIC ANAPLASTIC LARGE CELL LYMPHOMA AND DOCUMENTATION OF FAILURE OF AT LEAST 1 PRIOR MULTI-AGENT CHEMOTHERAPY REGIMEN. DX OF PRIMARY CUTANEOUS ANAPLASTIC LARGE CELL LYMPHOMA OR CD30 EXPRESSING MYCOSIS FUNGOIDES AND DOCUMENTATION OF FAILURE OF PRIOR RADIATION OR SYSTEMIC THERAPY. DX OF PREVIOUSLY UNTREATED STAGE III OR IV CHL AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH CHEMOTHERAPY.

AGE RESTRICTION
PEDIATRIC CHL: MUST BE 2 YEARS OF AGE OR OLDER, ALL OTHERS: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

FOR STAGE III OR IV CHL: 6 MONTHS. FOR PEDIATRIC CHL: 15 WEEKS. ALL OTHER INDICATIONS: REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

SUBSEQUENT APPROVAL WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. AUTHORIZATION BEYOND 6 MONTHS FOR STAGE III OR IV CHL WILL REQUIRE DOCUMENTATION OF WELL-CONTROLLED, PEER-REVIEWED LITERATURE WITH EVIDENCE TO SUPPORT TREATMENT BEYOND 6 MONTHS. AUTHORIZATION BEYOND 15 WEEKS FOR PEDIATRIC CHL WILL REQUIRE DOCUMENTATION OF WELL-CONTROLLED, PEER-REVIEWED LITERATURE WITH EVIDENCE TO SUPPORT TREATMENT BEYOND 15 WEEKS.

ADCIRCA(GHP)

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation that tadalafil will not be used concomitantly with organic nitrate therapy

ADEMPAS(GHP)

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
WHO FUNCTIONAL CLASS II, III, OR IV SYMPTOMS AND EITHER DOCUMENTATION OF WHO GROUP 1 PULMONARY ARTERIAL HYPERTENSION OR CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4) WHICH IS INOPERABLE OR PREVIOUSLY TREATED SURGICALLY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CHRONIC-THROMBOEMBOLIC PULMONARY HYPERTENSION: DOCUMENTATION OF A BASELINE 6-MINUTE WALKING DISTANCE. 6 MONTH REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF AN IMPROVEMENT IN 6-MINUTE WALKING DISTANCE FROM BASELINE OR IMPROVED OR STABLE DIAGNOSIS OF WHO FUNCTIONAL CLASS. PULMONARY ARTERIAL HYPERTENSION: DOCUMENTATION OF A BASELINE 6-MINUTE WALKING DISTANCE. FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BOSENTAN, OR DOCUMENTATION OF USE IN COMBINATION WITH BOSENTAN. 6 MONTH REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF AN IMPROVEMENT IN 6-MINUTE WALKING DISTANCE FROM BASELINE

OR IMPROVED OR STABLE DIAGNOSIS OF WHO FUNCTIONAL CLASS.

AFINITOR DISPERZ(GHP)

MEDICATION(S)
EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB SOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS) who require therapeutic intervention but are not candidates for curative surgical resection OR adjunctive treatement of of Tuberous Sclerosis Complex (TSC) associated partial-onset seizures

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For TSC associated partial onset seizures: documentation of a therapeutic failure on, intolerance to, or contraindication to 2 anti-epileptic drug (AED) regimens. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

AFINITOR(GHP)

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 5 MG TAB, EVEROLIMUS 7.5 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RENAL CELL CARCINOMA. DX OF HORMONE-RECEPTOR POSITIVE, HER-2 NEGATIVE ADVANCED BREAST CANCER. DX OF PROGRESSIVE NEUROENDOCRINE TUMORS OF PANCREATIC ORIGIN (PNET) THAT IS UNRESCTABLE, LOCALLY ADVANCED OR METASTATIC. DX OF PROGRESSIVE, WELL DIFFERENTIATED, NON-FUNCTIONAL NEUROENDOCRINE TUMORS OF GASTROINTESTINAL (GI) ORIGIN OR LUNG ORIGIN THAT ARE UNRESECTABLE, LOCALLY ADVANCED, OR METASTATIC. DX OF SUBEPENDYMAL GIANT CELL ASTROCYTOMA (SEGA) ASSOCIATED WITH TUBEROUS SCLEROSIS (TS) WHO REQUIRE THERAPEUTIC INTERVENTION BUT ARE NOT CANDIDATES FOR CURATIVE SURGICAL RESECTION. DX OF RENAL ANGIOMYOLIPOMA AND TUBUEROUS SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS NOT REQUIRING IMMEDIATE SURGERY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST, NEPHROLOGIST, UROLOGIST, or NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR RENAL CELL CARCINOMA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR

CONTRAINDICATION TO sunitinib (SUTENT) or sorafenib (NEXAVAR). FOR BREAST CANCER: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PREVIOUS ENDOCRINE THERAPY TREATMENT AND EVEROLIMUS MUST BE USED IN COMBINATION WITH AN AROMATASE INHIBITOR. FOR RENAL ANGIOMYOLIPOMA AND TUBUEROUS SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS: AT LEAST ONE ANGIOMYOLIPOMA OF GREATER THAN OR EQUAL TO 3CM IN LONGEST DIAMETER ON CT/MRI BASED ON LOCAL RADIOLOGY ASSESSMENT. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

AIMOVIG(GHP)

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of migraine with or without aura AND documentation of the number of baseline migraine or headache days per month.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
Provider attestation of a therapeutic failure on, intolerance to, or contraindication to at least two of the following: one beta blocker (i.e., metoprolol, propranolol, timolol, atenolol, nadolol), topiramate, divalproex or sodium valproate, amitriptyline, or venlafaxine. Attestation that medication is not being used concurrently with botulinum toxin OR if being used in combination attestation of the following: therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND attestation of a therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist. Attestation that medication will not be used concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine. Reauthorization will require attestation of continued or sustained reduction in migraine or headache frequency or a decrease in severity or duration of migraine AND either attestation that the

medication is not being used concurrently with botulinum toxin OR if the request is for combination use with Botox attestation of the following: previous therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND attestation of a previous therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist AND Attestation that medication will not be used concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine.

AJOVY(GHP)

MEDICATION(S)
AJOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of migraine with or without aura AND documentation of the number of baseline migraine or headache days per month.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: Emgality, Aimovig, Nurtec. Documentation that medication is not being used concurrently with botulinum toxin OR if being used in combination documentation of the following: therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND documentation of a therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist. Documentation that medication will not be used concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine. Reauthorization will require documentation of continued or sustained reduction in migraine or headache frequency or a decrease in severity or duration of migraine AND either documentation the medication is not being used concurrently with botulinum toxin OR if the request is for combination use with Botox

documentation of the following: previous therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND documentation of a previous therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist AND documentation that medication will not be used concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine.

AKEEGA(GHP)

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of metastatic castration-resistant prostate cancer AND documentation of deleterious or suspected deleterious BRCA-mutation (BRCAm) as detected by an FDA approved test AND documentation that medication will be given in combination with prednisone.

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
Oncologist or urologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR documentation of bilateral orchiectomy. Reauthorizations will require documentation of continued disease improvement or lack of disease progression

AKYNZEO(GHP)

MEDICATION(S)
AKYNZEO 300-0.5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR THE PREVENTION OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING IN PATIENTS WHO ARE RECEIVING MODERATELY TO HIGHLY EMETOGENIC CHEMOTHERAPY, INCLUDING, BUT ARE NOT LIMITED TO REGIMENS CONTAINING BENDAMUSTINE, CARBOPLATIN, CISPLATIN, CYCLOPHOSPHAMIDE, DACARBAZINE, DOXORUBICIN, IFOSFAMIDE, IRINOTECAN, OXALIPLATIN, AND TEMOZOLOMIDE

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

ALDURAZYME(GHP)

MEDICATION(S)
ALDURAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HURLER FORM OF MPS I OR HURLER-SCHEIE FORM OF MPS I OR SCHEIE FORM OF MPS WITH MODERATE TO SEVERE SYMPTOMS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR GENETICIST WITH EXPERIENCE TREATING MUCOPOLYSACCHARIDOSIS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A

ALECENSA(GHP)

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF ALK-POSITIVE, METASTATIC NON-SMALL CELL LUNG CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ALINIA(GHP)

MEDICATION(S)
NITAZOXANIDE 500 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIARRHEA CAUSED BY GIARDIA LAMBLIA OR CRYPTOSPORIDIUM PARVUM

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

ALIQOPA(GHP)

MEDICATION(S)
ALIQOPA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELPASED FOLLICULAR LYMPHOMA (FL) WITH DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO PRIOR SYSTEMIC THERAPIES

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ALKINDI(GHP)

MEDICATION(S)
ALKINDI SPRINKLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ADRENOCORTICAL INSUFFICIENCY.

AGE RESTRICTION
MUST BE 17 YEARS OF AGE OR YOUNGER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF DIFFICULTY SWALLOWING OR THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO GENERIC FORMULARY CORTICOSTEROIDS, ONE OF WHICH MUST BE HYDROCORTISONE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF AGE APPROPRIATENESS AND NEED FOR SPRINKLE FORMULATION.

ALOXI(GHP)

MEDICATION(S)
PALONOSETRON HCL 0.25 MG/5ML SOLN PRSYR, PALONOSETRON HCL 0.25 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA OR VOMITING FROM LOW OR MINIMALLY EMETOGENIC CHEMOTHERAPY OR DOCUMENTATION OF USE FOR PREVENTION OF ACUTE OR DELAYED NAUSEA AND VOMITING ASSOCIATED WITH INITIAL AND REPEAT COURSES OF MODERATELY OR HIGHLY EMETOGENIC CHEMOTHERAPY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR LOW OR MINIMALLY EMETOGENIC CHEMOTHERAPY: TREATMENT FAILURE OR CONTRAINDICATION TO GRANISETRON OR ONDANSETRON. TREATMENT FAILURE IS DEFINED AS AN ALLERGY, INTOLERABLE SIDE EFFECTS, SIGNIFICANT DRUG-DRUG INTERACTION, OR LACK OF EFFICACY

ALUNBRIG(GHP)

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of ALK-positive, metastatic non-small cell lung cancer

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

AMONDYS(GHP)

MEDICATION(S)
AMONDYS 45

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF DUCHENNE'S MUSCULAR DYSTROPHY CONFIRMED BY GENETIC TESTING WITH MUTATION OF THE DMD GENE THAT IS AMENABLE BY EXON 45 SKIPPING CONFIRMED BY A GENETIC COUNSELOR AND DOCUMENTATION THAT MEDICATION IS BEING GIVEN CONCURRENTLY WITH ORAL CORTICOSTEROIDS UNLESS CONTRAINDICATED OR INTOLERANT AND DOCUMENTATION THAT THE PATIENT IS AMBULATORY (ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND) AS PROVEN BY DOCUMENTATION OF A 6-MINUTE WALK TEST DISTANCE WITHIN THE PAST 3 MONTHS OF INITIATION OF AMONDYS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR GENETIC SPECIALIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A DOSE CONSISTENT WITH THE FDA APPROVED LABELING. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED BENEFIT FROM TREATMENT, DOCUMENTATION OF CONTINUED CONCURRENT USE WITH ORAL CORTICOSTEROIDS, DOCUMENTATION OF A DOSE CONSISTENT WITH FDA APPROVED LABELING, AND DOCUMENTATION THAT THE PATIENT REMAINS AMBULATORY AS PROVEN

BY DOCUMENTATION OF A FOLLOW UP 6 MINUTE WALK TEST DISTANCE WITHIN THE PAST 6 MONTHS

AMVUTTRA(GHP)

MEDICATION(S)
AMVUTTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR) as confirmed by genetic testing to confirm a pathogenic mutation in TTR AND documentation of either biopsy of tissue or organ to confirm amyloid presence OR a clinical manifestation typical of hATTR (such as neuropathy or CHF) without a better alternative explanation. Documentation of medication being used to treat polyneuropathy. Documentation of familial amyloid polyneuropathy (FAP) stage 1-2 OR polyneuropathy disability score indicating the patient is not wheelchair bound or bedridden.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with neurologist, board certified medical geneticist, or specialist with experience treating hATTR

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of a dose and duration of therapy that is consistent with FDA-approved labeling, nationally recognized compendia, or peer-reviewed medical leterature. Documentation that medication will not be used in combination with other RNA interference treatments. Reauthorization will require (1) documentation of medical necessity, (2) documentation of a dose and duration of therapy that is consistent with FDA-approved labeling, nationally recognized compendia, or peer-reviewed medical

leterature, and (3) no documentation of FAP stage 3 OR polyneuropathy disability score indicating the patient is wheelchair-bound or bedridden.

ANTIPARKINSON AGENT HRM(GHP)

MEDICATION(S)
TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HCL 0.4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF EXTRAPYRAMIDAL SIDE EFFECTS (EPS) OR PARKINSON'S DISEASE

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF EPS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AMANTADINE. DIAGNOSIS OF PARKINSON'S WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CARBIDOPA/LEVODOPA, PRAMIPEXOLE, ROPINIROLE.

APTIOM(GHP)

MEDICATION(S)
APTIOM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTION
MUST BE 4 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTICONVULSANTS USED FOR THE REQUESTED DIAGNOSIS, ONE OF WHICH MUST BE OXCARBAZEPINE.

ARALAST(GHP)

MEDICATION(S)
ARALAST NP, PROLASTIN-C

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF PANACINAR EMPHYSEMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A DECLINE IN FORCED EXPIRATORY VOLUME IN 1 SECOND (FEV1) DESPITE MEDICAL THERAPY WITH BRONCHODILATORS AND/OR CORTICOSTEROIDS AND DOCUMENTATION OF PHENOTYPE ASSOCIATED WITH CAUSING SERUM ALPHA 1-ANTITRYPSIN OF LESS THAN 80 MG/DL AND DOCUMENTATION OF AN ALPHA 1-ANTITRYPSIN SERUM LEVEL BELOW THE VALUE OF 35% OF NORMAL (LESS THAN 80 MG/DL).

ARANESP(GHP)

MEDICATION(S)
ARANESP (ALBUMIN FREE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TX OF ANEMIA OF CHRONIC RENAL INSUFFICIENCY, CHRONIC RENAL FAILURE, INCLUDING ESRD and HEMOGLOBIN (HGB) MUST BE LESS THAN OR EQUAL TO 10GM/DL FOR NEW STARTS or LESS THAN 10 GM/DL FOR CONTINUATION OF THERAPY FOR CKD NOT ON DIALYSIS, LESS THAN 11 GM/DL FOR CKD ON DIALYSIS, OR LESS THAN 12 GM/DL FOR PEDIATRIC CKD, OR DOCUMENTATON THAT THE DOSE WILL BE REDUCED OR INTERRUPTED. TX OF ANEMIA IN NON-MYELOID MALIGNANCY - MUST BE ON ANEMIA CAUSING CHEMO AND THERE IS A MINIMUM OF TWO ADDITIONAL MONTHS OF PLANNED CHEMOTHERAPY and HGB MUST BE LESS THAN OR EQUAL TO 10GM/DL FOR NEW STARTS or LESS THAN 10 GM/DL FOR CONTINUATION OF THERAPY or DOCUMENTATON THAT THE DOSE WILL BE REDUCED OR INTERRUPTED. FOR ALL INDICATIONS: DOCUMENTATION OF ADEQUATE IRON STORES W/ SERUM FERRITIN GREATER THAN 100 NG/ML OR TRANSFERRIN LEVEL SATURATION GREATER THAN 20% OR A HISTORY OF CHELATION THERAPY FOR IRON.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

REAUTHORIZATION WILL REQUIRE REPEAT HGB (WITHIN 3 MONTHS OF REAUTH) AND FERRITIN OR TSAT LEVELS (WITHIN 6 MONTHS OF REAUTH). THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

ARAZLO(GHP)

MEDICATION(S)
ARAZLO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACNE, ACNE VULGARIS, OR ADULT-ONSET ACNE.

AGE RESTRICTION
MUST BE 9 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR MEMBERS 12 YEARS OF AGE AND OLDER: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY TOPICAL RETINOIDS, SUCH AS BUT NOT LIMITED TO ADAPALENE AND TRETINOIN.

ARCALYST(GHP)

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS), INCLUDING FAMILIAL COLD AUTOINFLAMMATORY SYNDROME (FCAS), AND MUCKLE-WELLS SYNDROME (MWS) SUPPORTED BY DOCUMENTATION OF GENETIC TESTING TO IDENTIFY THE CIAS1/NLRP-3 GENE MUTATION. DX OF DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA) SUPPORTED BY DOCUMENTATION OF A HOMOZYGOUS OR COMPOUND HETEROZYGOUS MUTATION IN IL 1 RN (INTERLEUKIN 1 RECEPTRO ANTAGONIST GENE) AND DOCUMENTATION THAT MEDICATION IS BEING USED FOR MAINTENANCE OF REMISSION OF DIRA. DX OF RECUURENT PERICARDITIS (RP) AS EVIDENCED BY A RECURRENCE OF PERICARDITIS AFTER A SYMPTOM FREE INTERVAL OF 4 TO 6 WEEKS OR LONGER FOLLOWING A DOCUMENTED EPEISODE OF ACUTE PERICARDITIS.

AGE RESTRICTION
FOR RECURRENT PERICARDITIS: 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
IMMUNOLOGIST, RHEUMATOLOGIST, PEDIATRICIAN, ALLERGIST OR CARDIOLOGIST

COVERAGE DURATION
3 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
FOR CAPS: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO KINERET. REAUTHORIZATION WILL REQUIRE CONTINUED

IMPROVEMENT IN THE SIGNS AND SYMPTOMS OF THE DISEASE. FOR DIRA: DOCUMENTATION OF A MEMBER WEIGHT GREATER THAN OR EQUAL TO 10 KG AND DOCUMENTATION OF REMISSION OF DIRA THAT WAS INDUCED BY ANAKINRA AND DOCUMENTATION OF THERAPEUTIC FAILURE, INTOLERANCE OR CONTRAINDICATION OF CONTINUING ANAKINRA. FOR RP: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO (1) COLCHICINE AND (2) A NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) OR ASPIRIN. REAUTHORIZATION WILL REQUIRE MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ARISTADA INITIO(GHP)

MEDICATION(S)
ARISTADA INITIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of schizophrenia AND documentation that medication is being used for treatment initiation with transition to Aristada.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 MONTH

OTHER CRITERIA
Documentation that Aristada Initio will be given as a single dose in combination with one 30 mg dose of oral aripiprazole and the first month's dose of Aristada. Documentation of a therapeutic failure on or intolerance to the oral equivalent form of the medication.

ARZERRA(GHP)

MEDICATION(S)
ARZERRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT CLL IS REFRACTORY TO BOTH FLUDARABINE AND ALEMTUZUMAB OR FOR PREVIOUSLY UNTREATED: DOCUMENTATION OF USE IN COMBINATION WITH CHLORAMBUCIL AND DOCUMENTATION OF INABILITY TO USE FLUDARABINE OR FOR RELAPSE: DOCUMENTATION OF USE IN COMBINATION WITH FLUDARABINE AND CYCLOPHOSPHAMIDE OR FOR EXTENDED TREATMENT: DOCUMENTATION OF COMPLETE OR PARTIAL RESPONSE AFTER AT LEAST TWO LINES OF THERAPY FOR RECURRENT OR PROGRESSIVE DISEASE. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ASTAGRAF(GHP)

MEDICATION(S)
ASTAGRAF XL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of kidney transplant.

AGE RESTRICTION
Must be 4 years of age or older

PRESCRIBER RESTRICTION
TRANSPLANT SPECIALIST OR PHYSICIAN EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
If greater than 18 years of age: documentation of rationale for not using Envarsus XR if clinically appropriate.

AUGTYRO(GHP)

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS ARE ROS1-POSITIVE.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

AUSTEDO(GHP)

MEDICATION(S)
AUSTEDO, AUSTEDO PATIENT TITRATION KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Huntingtons disease AND documentation of symptoms of chorea AND documentation of baseline total maximal chorea score prior to initiating therapy AND either evaluation by a psychiatrist if there is a history of prior suicide attempt, bipolar disorder, or major depressive disorder OR documentation of a mental health evaluation performed by the prescriber. Diagnosis of tardive dyskinesia as evidenced by either moderate to severe abnormal body movements (AIMS score 3 or 4) in at least 1 body area or mild abnormal body movements (AIMS score 1 or 2) in 2 or more body areas AND documentation of no other causes of involuntary movements AND documentation of baseline AIMS score prior to initiating therapy AND if the symptoms are related to use of a first-generation antipsychotic, documentation that a switch to a second generation antipsychotic has been attempted and did not resolve symptoms OR provider rationale as to why a switch to a second generation antipsychotic would not be appropriate.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH PSYCHIATRIST, NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

For Huntingtons: therapeutic failure on, intolerance to or contraindication to tetrabenazine. For tardive dykinesia: therapeutic failure on, intolerance to, or contraindication to valbenazine. Reauthorization for huntingtons will require documentation of an improvement in chorea as evidenced by a reduction in the total maximal chorea score from baseline. Reauthorization for tardive dyskinesia will require documentation of an improvement in symptoms as evidenced by a reduction from baseline AIMS score.

AUVELITY(GHP)

MEDICATION(S)
AUVELITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON OR INTOLERANCE TO TWO ANTIDEPRESSANT CLASSES.

AVSOLA(GHP)

MEDICATION(S)
AVSOLA, INFLECTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CROHN'S DISEASE- DIAGNOSIS OF MODERATE TO SEVERE CROHN'S AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 12 WEEKS OF HUMIRA THERAPY OR DIAGNOSIS OF CROHN'S WITH ACTIVE DRAINING FISTULAS. RA - DIAGNOSIS OF MODERATE TO SEVERE RA MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA AND BEING USED IN CONJUNCTION WITH METHOTREXATE. ANKYLOSING SPONDYLITIS - DIAGNOSIS OF ANKYLOSING SPONDYLITIS. PLAQUE PSORIASIS - DIAGNOSIS OF CHRONIC, SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE PSA AND HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS. ULCERATIVE COLITIS - DIAGNOSIS OF MODERATE TO SEVERE UC

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS OF AGE FOR THE FOLLOWING DIAGNOSES - RA, ,ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, PSORIATIC ARTHRITIS. MUST BE AT LEAST 6 YEARS OF AGE FOR CROHNS DISEASE AND ULCERATIVE COLITIS.

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, DERMATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ). FOR UC: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR UC (HUMIRA, RINVOQ, SIMPONI, XELJANZ) OR DOCUMENTATION THAT AVOSLA IS BEING PRESCRIBED TO INDUCE DISEASE REMISSION. FOR PSORIATIC ARTHRITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR PSA (ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA, RINVOQ, XELJANZ, COSENTYX). FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PP (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA). FOR ANKYLOSING SPONDYLITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR AS (COSENTYX, HUMIRA, RINVOQ, XELJANZ). FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

AVYCAZ(GHP)

MEDICATION(S)
AVYCAZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF COMPLICATED INTRA-ABDOMINAL INFECTION (cIAI) CAUSED BY ONE OF THE FOLLOWING SUSCEPTIBLE MICROORGANISMS: Citrobacter freundii complex, Enterobacter cloacae, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, OR Pseudomonas aeruginosa. DIAGNOSIS OF HOSPITAL-ACQUIRED BACTERIAL PNEUMONIA (HABP) OR VENTILATOR-ASSOCIATED BACTERIAL PNEUMONIA (VABP) CAUSED BY ONE OF THE FOLLOWING SUSCEPTIBLE MICROORGANISMS: K. pneumoniae, E. cloacae, E. coli, Serratia marcescens, P. mirabilis, P. aeruginosa, OR Haemophilus influenzae. DIAGNOSIS OF COMPLICATED URINARY TRACT INFECTIONS (UTI) CAUSED BY ONE OF THE FOLLOWING SUSCEPTIBLE MICROORGANISMS: C. freundii complex, E. cloacae, E. coli, K. pneumoniae, P. mirabilis, OR P. aeruginosa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA
FOR cIAI: DOCUMENTATION THAT AVYCAZ WILL BE USED IN COMBINATION WITH METRONIDAZOLE. MEDICAL RECORD DOCUMENTATION OF A CULTURE AND SENSITIVITY

SHOWING THE PATIENTS INFECTION IS NOT SUSCEPTIBLE TO ALTERNATIVE ANTIBIOTIC TREATMENTS OR A DOCUMENTED HISTORY OF PREVIOUS INTOLERANCE TO OR CONTRAINDICATION TO TWO PREFERRED ALTERNATIVE FORMULARY ANTIBIOTICS SHOWN TO BE SUSCEPTIBLE ON CULTURE AND SENSITIVITY.

AYVAKIT(GHP)

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC GASTROINTESTINAL STROMAL TUMOR (GIST) AND DOCUMENTATION OF A PLATELET-DERIVED GROWTH FACTOR RECEPTOR ALPHA (PDGFRA) EXON 18 MUTATION. DIAGNOSIS OF ADVANCED SYSTEMIC MASTOCYTOSIS (ADVSM), INCLUDING: AGGRESSIVE SYSEMIC MASTOCYTOSIS (ASM), SYSTEMIC MASTOCYTOSIS WITH AN ASSOCIATED HEMATOLOGICAL NEOPLASM (SM-AHN), OR MAST CELL LEUKEMIA (MCL). DIAGNOSIS OF INDOLENT SYSTEMIC MASTOCYTOSIS (ISM).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST, HEMATOLOGIST, ALLERGIST OR IMMUNOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR AdvSM AND ISM: DOCUMENTATION OF A PLATELET COUNT GREATER THAN OR EQUAL TO 50 X 109/L. FOR ISM: DOCUMENTATION OF A DOSE CONSISTENT WITH FDA-APPROVED LABELING. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

BACLOFEN(GHP)

MEDICATION(S)
BACLOFEN 10 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of spasticity from multiple sclerosis OR spinal cord injuries and/or diseases.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of inability to tolerate or swallow tablets OR documentation of therapeutic failure on or contraindication to baclofen tablets and tizanidine tablets.

BALVERSA(GHP)

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 genetic alterations, that has progressed during or following at least one prior line of systemic therapy.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

BANZEL(GHP)

MEDICATION(S)
RUFINAMIDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF LENNOX-GASTAUT SYNDROME or FOR USE IN REFRACTORY PARTIAL SEIZURES AS DEFINED AS FAILURE ON TWO FORMULARY SEIZURE MEDICATIONS

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

BAVENCIO(GHP)

MEDICATION(S)
BAVENCIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF METASTATIC MERKEL CELL CARCINOMA (MCC). DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CARCINOMA WITH ONE OF THE FOLLOWING: DISEASE PROGRESSION DURING OR FOLLOWING PLATINUM-CONTAINING CHEMOTHERAPY OR DISEASE PROGRESSION WITHIN 12 MONTHS OF NEOADJUVANT OR ADJUVANT TREATMENT WITH PLATINUM-CONTAINING CHEMOTHERAPY OR FOR USE AS MAINTENANCE TREATMENT WITH NO PROGRESSION FOLLOWING FIRST-LINE PLATINUM CONTAINING CHEMOTHERAPY. DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA AND DOCUMENTATION OF USE AS FIRST LINE TREATMENT IN COMBINATION WITH AXITINIB.

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS RENEWAL

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

BAXDELA(GHP)

MEDICATION(S)
BAXDELA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of either a diagnosis of acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of the following: Staphylococcus aureus (including methicillin-resistant (MRSA) and methicillin-susceptible (MSSA) isolates), Staphylococcus haemolyticus, Staphylococcus lugdunensis, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), Streptococcus pyogenes, Enterococcus faecalis, Escherichia coli, Enterobacter cloacae, Klebsiella pneumoniae, or Pseudomonas aeruginosa OR Documentation of community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: Streptococcus pneumoniae, Staphylococccus aureus (MSSA isolates only), Klebsiella pneumoniae, Escherichia coli, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae, Chlamydia pneumoniae, Legionella pneumophila, or Mycloplasma pneumoniae AND documentation of culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments OR a documented history of previous intolerance to or contraindication to other antibiotics shown to be susceptible on the culture and sensitivity OR documentation that therapy was initiated during an inpatient setting.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA

For Baxdela injection formulation: documentation of reason why the oral formulation cannot be tried or is not appropriate.

BECONASE AQ(GHP)

MEDICATION(S)
BECONASE AQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of allergic or vasomotor rhinitis OR documentation of use for the prevention of nasal polyps.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For rhinitis: documentation of failure on, intolerance to, or contraindication to two formulary agents (flunisolide, fluticasone propionate, mometasone, budesonide). For prevention of nasal polyps: documentation of failure on, intolerance to, or contraindication to mometasone.

BELEODAQ(GHP)

MEDICATION(S)
BELEODAQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY PERIPHERAL T-CELL LYMPHOMA

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

BEMPEDOIC ACID(GHP)

MEDICATION(S)
NEXLETOL, NEXLIZET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF EITHER CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD), INCLUDING ACUTE CORONARY SYNDROMES (A HISTORY OF MYOCARDIAL INFARCTION OR UNSTABLE ANGINA), CORONARY OR OTHER ARTERIAL REVASCULARIZATION, STROKE, TRANSIENT ISCHEMIC ATTACK, OR PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN OR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH). FOR HEFH ONE OF THE FOLLOWING: GENETIC TESTING TO CONFIRM MUTATION IN THE LDL RECEPTOR, PCSK9, OR APOB GENE OR DOCUMENTATION OF DEFINITE HEFH (SCORE GREATER THAN 8) ON THE DIAGNOSTIC CRITERIA SCORING SYSTEM AS DEFINED BY THE DUTCH LIPID CLINIC NETWORK DIAGNOSTIC CRITERIA. DOCUMENTATION OF A BASELINE LDL DRAWN WITHIN 3 MONTHS OF THE START OF THERAPY SHOWING AN LDL GREATER THAN 100 IF USING FOR HEFH AND USING FOR PRIMARY PREVENTION OR AN LDL GREATER THAN 70 IF USING FOR SECONDARY PREVENTION. FOR STATIN TOLERANT PATIENTS, DOCUMENTATION OF AN INABILITY TO ACHIEVE AND MAINTAIN LDL GOAL WITH ONE OF THE FOLLOWING (1) MAXIMUM TOLERATED DOSE OF A HIGH INTENSITY STATIN (ATORVASTATIN 40 MG OR HIGHER OR ROSUVASTATIN 20 MG OR HIGHER) OR (2) A MAXIMALLY TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT HAS HAD A PREVIOUS TRIAL OF EITHER ATORVASTATIN OR ROSUVASTATIN, WITH PRESCRIBERS DOCUMENTATION REGARDING LENGTH OF PREVIOUS TRIALS OF STATINS. PATIENT MUST INTEND TO CONTINUE ON MAXIMAL STATIN THERAPY ONCE BEMPEDOIC ACID THERAPY IS STARTED. FOR STATIN INTOLERANT PATIENTS, DOCUMENTATION OF REASON FOR STATIN INTOLERANCE.

AGE RESTRICTION

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Documentation of therapeutic failure of a trial of ezetemibe alone. Therapeutic failure is defined as an inability to reach target LDL goals (less than 100 mg/dL for patients with HeFH in primary prevention or less than 70 mg/dL for ASCVD or for patients with HeFH using Praluent as secondary prevention) despite at least a 3 month trial. Intolerance to statins is defined as increased LFTs, intolerable myalgia (muscle symptoms without creatinine kinase (CK) elevations) or myopathy (muscle symptoms with CK elevations), or myositis (elevations in CK without muscle symptoms), which persist after two retrials with a different dose or different dosing strategy (every other day) of alternative moderate- or high-intensity statin. Contraindications to statins are defined as active liver disease, previous history of rhabdomyolysis, or hypersensitivity.

BENLYSTA(GHP)

MEDICATION(S)
BENLYSTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS AND DOCUMENTATION THAT PATIENT HAS ACTIVE DISEASE or RECURRENT FLARES or INABILITY TO WEAN STEROIDS IN SLE. DOCUMENTATION OF A POSITIVE ANA/ANTI-DSDNA ANTIBODY. DOCUMENTATION THAT MEDICATION IS BEING USED IN COMBINATION WITH, OR PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO, STANDARD THERAPY (SUCH AS BUT NOT LIMITED TO CORTICOSTEROIDS, NSAIDS ANTI-MALARIALS OR IMMUNOSUPPRESSANTS). DOCUMENTATION OF NO CNS INVOLVEMENT. DOCUMENTATION OF A DIAGNOSIS OF ACTIVE LUPUS NEPHRITIS, CLASS III, IV, V ALONE OR IN COMBINATION, CONFIRMED BY A KIDNEY BIOPSY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR NEPHROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR LUPUS NEPHRITIS: DOCUMENTATION THAT MEDICATION WILL BE PRESCRIBED IN COMBINATION WITH STANDARD THERAPY (SUCH AS MYCOPHENOLATE MOFETIL (MMF), CORTICOSTEROIDS, CYCLOPHOSPHAMIDE, OR AZATHIOPRINE). REAUTHORIZTION FOR

LUPUS NEPHRITIS WILL REQUIRE DOCUMENTATION OF A POSITIVE CLINICAL RESPONSE TO THERAPY (SUCH AS IMPROVEMENT OR STABILIZATION IN UPCR, eGFR, OR RENAL RELATED EVENTS) and DOCUMENTATION OF CONTINUED USE IN COMBINATION WITH STANDARD THERAPY. REAUTHORIZATION FOR SLE WILL REQUIRE DOCUMENTATION SHOWING CLINICAL BENEIFT OF ONE OF THE FOLLOWING: IMPROVEMENT IN FUNCTIONAL IMPAIRMENT, DECREASE IN THE NUMBER OF EXACERBATIONS SINCE STARTING THERAPY, OR DECREASE IN THE DAILY REQUIRED DOSE OF ORAL CORTICOSTEROIDS

BESPONSA(GHP)

MEDICATION(S)
BESPONSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL)

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
ONE TIME REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF THE FOLLOWING: PATIENT IS NOT RECEIVING HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) AND HAS ACHIEVED COMPLETE REMISSION OR COMPLETE REMISSION WITH INCOMPLETE HEMATOLOGIC RECOVERY AND MINIMAL RESIDUAL DISEASE (MRD) AND IS NOT EXPERIENCING TOXICITY OR WORSENING OF DISEASE.

BESREMI(GHP)

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF POLYCYTHEMIA VERA

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF AN INADEQUATE RESPONSE OR INTOLERANCE TO HYDROXYUREA. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

BETHKIS(GHP)

MEDICATION(S)
TOBRAMYCIN 300 MG/4ML NEBU SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CYSTIC FIBROSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

BEXAROTENE GEL(GHP)

MEDICATION(S)
BEXAROTENE 1 % GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of cutaneous lesions of stage IA or IB Cutaneous T-cell lymphoma (CTCL) in patients who have refractory or persistent disease after other therapies or who have not tolerated other therapies.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
Prescribed by or in consultation with oncologist or dermatologist.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION and DOCUMENTATION THAT MEMBER CONTINUES TO BE FOLLOWED BY AN ONCOLOGIST OR DERMATOLOGIST.

BEYFORTUS(GHP)

MEDICATION(S)
BEYFORTUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PROPHYAXIS OF SERIOUS LOWER RESPIRATORY TRACT DISEASE CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV) IN PEDIATRIC PATIENTS AT HIGH RISK, INCLUDING THOSE WITH BRONCHOPULMONARY DYSPLASIA OR COGENITAL HEART DISEASE, AND THOSE BORN PREMATURELY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
5 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEMBER HAS NOT RECEIVED SYNAGIS DURING THE CURRENT RSV SEASON.

BLINCYTO(GHP)

MEDICATION(S)
BLINCYTO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY CD19-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) OR DIAGNOSIS OF CD19-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) IN FIRST OR SECOND REMISSION WITH MINIMAL RESIDUAL DISEASE (MRD) GREATER THAN OR EQUAL TO 0.1%

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
RELAPSED OR REFRACTORY DISEASE: 20 MONTHS, MRD B CELL ALL: 6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF WELL-CONTROLLED PEER-REVIEWED LITERATURE WITH EVIDENCE SUPPORTING THE REQUEST.

BONIVA IV(GHP)

MEDICATION(S)
IBANDRONATE SODIUM 3 MG/3ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF OSTEOPOROSIS IN POSTMENOPAUSAL WOMEN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
INTOLERANCE TO ORAL BIPHOSPHONATES OR INABILITY TO REMAIN IN AN UPRIGHT POSITION FOR A MINIMUM OF 30-60 MINUTES AFTER INGESTION OR DISRUPTION OF THE ALIMENTARY TRACT DUE TO ANY OF THE FOLLOWING REASONS WHICH PRECLUDES THE USE OF ORAL BISPHOSPHONATES: OBSTRUCTING STRICTURE OR NEOPLASM OF THE ESOPHAGUS, STOMACH OR INTESTINE OR SHORT BOWEL SYNDROME SECONDARY TO EXTENSIVE SMALL BOWEL RESECTION OR MOTILITY DISORDER OR MALABSORPTION SECONDARY TO ENTEROVESICAL, ENTEROCUTANEOUS OR ENTEROCOLIC FISTULAS OR PROLONGED PARALYTIC ILEUS FOLLOWING SURGERY OR INJURY AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ZOLEDRONIC ACID. THIS DRUG MAY BE COVERED UNDER MEDICARE PART B, BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES (PART B) OR COVERED UNDER MEDICARE

PART D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

BONJESTA(GHP)

MEDICATION(S)
BONJESTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF NAUSEA AND VOMITING OF PREGNANCY IN ADULT WOMEN

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
9 MONTHS

OTHER CRITERIA
N/A

BOSULIF(GHP)

MEDICATION(S)
BOSULIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CHRONIC, ACCELERATED, OR BLAST PHASE PH POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (CML) or DOCUMENTATION OF NEWLY DIAGNOSED CHRONIC PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR ALL INDICATIONS EXCEPT NEWLY DIAGNOSED CHRONIC PHASE PHILADELPHIA CHROMOSOME POSITIVE CML: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING PRIOR THERAPIES IMATINIB, SPRYCEL, OR TASIGNA. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

BRAFTOVI(GHP)

MEDICATION(S)
BRAFTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic melanoma AND documentation that medication is being prescribed in combination with Mektovi AND documentation of BRAF V600E OR V600K mutation as detected by an FDA approved test. Documentation of metastatic colorectal cancer with progression on at least one prior therapy AND documentation that medication is being prescribed in combination with cetuximab AND documentation of a BRAF V600E mutation as detected by an FDA approved test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

BRIUMVI(GHP)

MEDICATION(S)
BRIUMVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF A RELAPSING FORM OF MULTIPLE SCLEROSIS (MS), INCLUDING CLINICALLY ISOLATED SYNDROME, RELAPSING-REMITTING DISEASE, AND ACTIVE SECONDARY PROGRESSIVE DISEASE AND DOCUMENTATION OF A HEPATITIS B SCREENING.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR THE TREATMENT OF MULTIPLE SCLEROSIS. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

BRIVIACT(GHP)

MEDICATION(S)
BRIVIACT 50 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PARTIAL-ONSET SEIZURES AND DOCUMENTATION THAT BRIVIACT IS NOT BEING USED IN COMBINATION WITH LEVETIRACETAM

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 WEEK

OTHER CRITERIA
DOCUMENTATION OF INABILITY TO USE ORAL FORMULATION OF MEDICATION.

BRONCHITOL(GHP)

MEDICATION(S)
BRONCHITOL, BRONCHITOL TOLERANCE TEST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of cystic fibrosis (CF) AND documentation of use as add-on maintenance therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
By or in consultation with a pulmonologist or CF specialist

COVERAGE DURATION
12 months

OTHER CRITERIA
Documentation of use in conjunction with standard CF therapies (such as, but not limited to: bronchodilators, antibiotics, or anti-inflammatory therapy). Documentation that patient has passed the bronchitol tolerance test. Reauthorization will require positive clinical response to therapy based on provider assessment.

BROVANA(GHP)

MEDICATION(S)
ARFORMOTEROL TARTRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF COPD

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SEREVENT OR DOCUMENTATION OF INABILITY TO USE AN INHALER.

BRUKINSA(GHP)

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MANTLE CELL LYMPHOMA (MCL) AND DOCUMENTATION OF THERAPEUTIC FAILURE ON OR INTOLERANCE TO ONE PRIOR THERAPY. DIAGNOSIS OF WALDENSTROM'S MACROGLOBULINEMIA. DIAGNOSIS OF RELAPSED OR REFRACTORY MARGINAL ZONE LYMPHOMA (MZL) AND DOCUMENTATION OF THERAPEUTIC FAILURE ON OR INTOLERANCE TO ONE PRIOR ANTI-CD20 BASED REGIMEN. DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL). DIAGNOSIS OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA AND DOCUMENTATION OF THERAPEUTIC FAILURE ON OR INTOLERANCE TO TWO PRIOR THERAPIES AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH OBINUTUZUMAB.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

BUDESONIDE ER(GHP)

MEDICATION(S)
BUDESONIDE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of ulcerative colitis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
8 WEEKS

OTHER CRITERIA
Documentation of failure on, intolerance to, or contraindication to sulfasalazine, balsalazide, or an oral mesalamine product

BYLVAY(GHP)

MEDICATION(S)
BYLVAY, BYLVAY (PELLETS)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PROGRESSIVE FAMILIAL INTRAHEPATIC CHOLESTASIS (PFIC). DOCUMENTATION OF THE PRESENCE OF MODERATE TO SEVERE PRURITIS. DOCUMENTATION OF A DIAGNOSIS ALAGILLE SYNDROME (ALGS) AND DOCUMENTATION OF THE PRESENCE OF MODERATE TO SEVERE PRURITUS.

AGE RESTRICTION
PFIC: 3 MONTHS OF AGE OR OLDER, ALGS: 12 MONTHS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF AN APPROPRIATE DOSE BASED ON PATIENTS WEIGHT. FOR PFIC: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO URSODIOL. FOR ALGS: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CHOLESTYRAMINE, RIFAMPIN, OR NALTREXONE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF 1) IMPROVEMENT IN PRURITIS AND/OR REDUCTION IN SERUM BILE ACID AND 2) DOCUMENTATION OF AN APPROPRIATE DOSE BASED ON THE PATIENTS WEIGHT.

CABLIVI(GHP)

MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP). Documentation of (1) use in combination with daily plasma exchange and immunosuppressive therapy (such as glucocorticoids or rituximab) AND documentation that the member has not experienced more than two recurrences of aTTP while on Cablivi OR (2) documentation that the member previously received daily plasma exchange, immunosuppresive therapy and Cablivi within the inpatient settings AND known date of the last plasma exchange AND documentation that the member has not experienced more than two recurrences of aTTP while on Cablivi AND documentation of either the date of plasma exchange is within 30 days of the request date OR if the date of plasma exchange is greater than 30 days of the request date, documentation of persistent underlying disease (such as suppressed ADAMTS 13 activity levels remain present) and documentation of not exceeding the maximum treatment duration of Cablivi (30 days post plasma exchange and up to 28 days of extended treatment).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a hematologist

COVERAGE DURATION
2 MONTHS INITIAL, 2 MONTHS REAUTH

OTHER CRITERIA
Reauthorization will be based on plasma exchange status and that member has not experienced more

than two recurrences of aTTP while on Cablivi. If currently receiving plasma exchange, documentation that medication is currently being used with plasma exchange and immunosuppressive therapy. If plasma exchange has been completed within 30 days, documentation of previously receiving daily plasma exchange and immunosuppressive therapy, the known date of the last plasma exchange, and that the date of plasma exchange is within 30 days of the request date. If plasma exchange has been completed for more than 30 days, documentation sign(s) of persistent underlying disease (such as suppressed ADAMTS13 activity levels remain present) AND date of last plasma exchange AND documentation of not exceeding the maximum treatment duration of Cablivi (30 days post plasma exchange and up to 28 days of extended treatment).

CABOMETYX(GHP)

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE IN COMBINATION WITH NIVOLUMAB FOR PREVIOUSLY UNTREATED ADVANCED RENAL CELL CARCINOMA OR DOCUMENTATION OF USE AS A SINGLE AGENT FOR RELAPSE OR FOR SURGICALLY UNRESECTABLE ADVANCED OR METASTATIC RENAL CELL CARCINOMA. DOCUMENTATION OF HEPATOCELLULAR CARCINOMA AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO SORAFENIB. DOCUMENTATION OF LOCALLY ADVANCED OR METASTATIC DIFFERENTIATED THYROID CANCER (DTC) AND DOCUMENTATION OF PROGRESSION FOLLOWING PRIOR VEGFR-TARGETED THERAPY AND DOCUMENTATION THAT MEMBER IS RADIOACTIVE IODINE-REFRACTORY OR INELIGIBLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
IF THE REQUESTED DOSE IS 80 MG DAILY, DOCUMENTATION THAT THE PATIENT IS USING IN COMBINATION WITH A STRONG CYP3A4 INDUCER, INCLUDING BUT NOT LIMITED TO, RIFAMPIN, PHENYTOIN, CARBAMAZEPINE, PHENOBARBITAL, RIFABUTIN, RIFAPENTINE, OR

ST. JOHN'S WORT. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

CALQUENCE(GHP)

MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy OR diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). If the requested dose is 400 mg daily, need documentation that the patient is using in combination with a strong CYP3A inducer, including but not limited to carbamazepine, enzalutamide, fosphenytoin, lumacaftor, mitotane, phenytoin, rifampin, or St. John's Wort.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

CAMZYOS(GHP)

MEDICATION(S)
CAMZYOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF NYHA CLASS II-III OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY AND DOCUMENTATION OF LEFT VENTRICULAR EJECTION FRACTION (LVEF) GREATER THAN OR EQUAL TO 55 PERCENT.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
CARDIOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: BETA BLOCKERS, NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS, OR DISOPYRAMIDE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF LVEF GREATER THAN OR EQUAL TO 50 PERCENT AND DOCUMENTATION OF CLINICAL IMPROVEMENT OR MAINTENANCE OF CONDITION.

CAPLYTA(GHP)

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA OR DEPRESSIVE EPISODES ASSOCIATED WITH BIPOLAR DISORDER (BIPOLAR DEPRESSION).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR SCHIZOPHRENIA: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ARIPIPRAZOLE) OR FOR BIPOLAR DEPRESSION: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO QUETIAPINE AND LATUDA.

CARBAGLU(GHP)

MEDICATION(S)
CARBAGLU, CARGLUMIC ACID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF HYPERAMMONEMIA DUE TO THE DEFICIENCY OF THE HEPATIC ENZYME N-ACETYLGLUTAMATE SYNTHASE (NAGS). DIAGNOSIS OF PROPIONIC ACIDEMIA (PA) OR METHYLMALONIC ACIDEMIA (MMA).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC DISORDER SPECIALIST OR GENETICIST

COVERAGE DURATION
For MMA or PA: 7 days. NAGS: 6 MONTHS

OTHER CRITERIA
FOR ALL INDICATIONS: DOCUMENTATION THAT MEDICATION IS PRESCRIBED WITH A DOSE AND DURATION OF THERAPY THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE. FOR MMA OR PA: (1)DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED AS ADJUNCTIVE TREATMENT TO STANDARD OF CARE (INCLUDING BUT NOT LIMITED TO INTRAVENOUS GLUCOSE, INSULIN, L-CARNITINE, PROTEIN RESTRICTION AND DIALYSIS), AND (2)DOCUMENTATION OF PLASMA AMMONIA LEVEL GREATER THAN OR EQUAL TO 50 MICROMOL/L. REAUTHORIZATIONS FOR NAGS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE

PROGRESSION

CAYSTON(GHP)

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CYSTIC FIBROSIS CONFIRMED BY APPROPRIATE DIAGNOSTIC OR GENETIC TESTING AND DOCUMENTATION THAT PSEUDOMONAS AERUGINOSA IS PRESENT IN THE CULTURES OF THE AIRWAY

AGE RESTRICTION
MUST BE 7 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TOBRAMYCIN INHALATION SOLUTION

CERDELGA(GHP)

MEDICATION(S)
CERDELGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF GAUCHER DISEASE TYPE 1 (GD1) AND DOCUMENTATION THAT MEMBER IS A CYTOCHROME P450 (CYP)2D6 EXTENSIVE METABOLIZER (EM), INTERMEDIATE METABOLIZER (IM), OR POOR METABOLIZER (PM) AS DETECTED BY AN FDA-CLEARED TEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRADINDICATION TO MIGLUSTAT.

CEREZYME(GHP)

MEDICATION(S)
CEREZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF TYPE 1 GAUCHER DISEASE ALONG WITH AT LEAST ONE OF THE FOLLOWING CONDITIONS: ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST, GENETICIST, OR HEMATOLOGIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO FOR THOSE 4 YEARS OF AGE AND OLDER. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

CHOLBAM(GHP)

MEDICATION(S)
CHOLBAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF BILE ACID SYNTHESIS DISORDERS DUE TO SINGLE ENZYME DEFECTS (SEDS) OR PEROXISOMAL DISORDERS (PDS) INCLUDING ZELLWEGER SPECTRUM DISORDERS IN PATIENTS WHO EXHIBIT MANIFESTATIONS OF LIVER DISEASE, STEATORRHEA, OR COMPLICATIONS FROM DECREASED FAT SOLUBLE VITAMIN ABSORPTION AND DOCUMENTATION THAT DIAGNOSIS HAS BEEN CONFIRMED WITH AN ABNORMAL URINARY BILE ACID FAST ATOM BOMBARDMENT IONIZATION MASS SPECTROMETRY (FAB-MS) ANALYSIS AND FOR THE TREATMENT OF PEROXISOMAL DISORDERS, DOCUMENTATION THAT MEDICATION WILL BE USED AS ADJUNCTIVE THERAPY AND DOCUMENTATION OF BASELINE ALT, AST, TOTAL BILIRUBIN, AND BODY WEIGHT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST, HEPATOLOGIST, OR METABOLIC SPECIALIST WITH EXPERIENCE IN THE DIAGNOSIS AND TREATMENT OF BILE ACID SYNTHESIS AND PEROXISOMAL DISORDERS

COVERAGE DURATION
3 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION SUPPORTING IMPROVEMENT IN TWO LABORATORY CRITERION (ALT OR AST VALUES REDUCED TO LESS THAN 50 U/L OR

BASELINE LEVELS REDUCED BY 80%, TOTAL BILIRUBIN VALUES REDUCED TO LESS THAN OR EQUAL TO 1 MG/DL, NO EVIDENCE OF CHOLESTASIS ON LIVER BIOPSY) OR ONE OF THE PRIOR LABORATORY CRITERIA IMPROVEMENTS IN ADDITION TO A BODY WEIGHT INCREASE OF 10% OR BODY WEIGHT STABLE AT GREATER THAN THE 50TH PERCENTILE.

CHORIONIC GONADOTROPIN(GHP)

MEDICATION(S)
CHORIONIC GONADOTROPIN 10000 UNIT RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PREPUBERTAL CRYPTORCHIDISM NOT CAUSED BY ANATOMICAL OBSTRUCTION IN MALE INFANTS AND CHILDREN OR DIAGNOSIS OF HYPOGONADOTROPIC HYPOGONADISM

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR HYPOGONADISM: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TRANSDERMAL TESTOSTERONE

CIALIS(GHP)

MEDICATION(S)
TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE FORMULARY 5-ALPHA REDUCTASE INHIBITOR (FINASTERIDE OR DUTASTERIDE) AND ONE FORMULARY ALPHA-1 ADRENERIGIC BLOCKER (ALFUZOSIN, TAMSULOSIN, DOXAZOSIN, TERAZOSIN)

CIBINQO(GHP)

MEDICATION(S)
CIBINQO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS.

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH AN ALLERGIST, DERMATOLOGIST, OR IMMUNOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH ANOTHER JAK INHIBITORS, BIOLOGIC IMMUNOMODULATORS, OR OTHER IMMUNOSUPPRESSANTS. FOR AD: DOCUMENTATION OF: (1) THERAPEUTIC FAILURE ON DAILY TREATMENT WITH AT LEAST ONE MEDIUM (OR HIGHER) POTENCY TOPICAL CORTICOSTEROID (SUCH AS BUT NOT LIMITED TO TRIAMCINOLONE, BETAMETHASONE, OR CLOBETASOL) OR CALCINEURIN INHIBITOR (I.E. TACROLIMUS) IF TOPICAL CORTICOSTEROIDS ARE NOT ADVISABLE AND (2) DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE SYSTEMIC THERAPY (SUCH AS BUT NOT LIMITED TO DUPIXENT OR ADBRY). REAUTHORIZATION WILL REQUIRE DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

CIMZIA(GHP)

MEDICATION(S)
CIMZIA, CIMZIA (2 SYRINGE), CIMZIA STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ADULT RA: DIAGNOSIS OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. CROHN'S DISEASE - DIAGNOSIS OF CROHN'S DISEASE. ANKYLOSING SPONDYLITIS - DIAGNOSIS OF ANKYLOSING SPONDYLITIS. PSORIATIC ARTHRITIS - DIAGNOSIS OF PSORIATIC ARTHRITIS AND DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS. DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS CHARACTERIZED BY GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA INVOLVED OR DISEASE INVOLVING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. Diagnosis of non-radiographic axial spondylarthritis with documentation of either C-reactive protein (CRP) level above the upper limit of normal or Sacroiliitis on magnetic resonance imaging (MRI).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, GASTROENTEROLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF

BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ). FOR PSORIATIC ARTHRITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PSA (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA, RINVOQ, XELJANZ). FOR PLAQUE PSORIASIS: FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PP (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA). FOR ANKYLOSING SPONDYLITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR AS (COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ). FOR CROHN'S: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA. FOR NR-AXSPA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

CINRYZE(GHP)

MEDICATION(S)
CINRYZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HEREDITARY ANGIOEDEMA and FOR HAE TYPE I AND TYPE II: THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDMEA WITHOUT URTICARIA SUPPORTED BY DOCUMENTATION OF LOW C4 LEVELS AND LESS THAN 50 PERCENT OF THE LOWER LIMIT OF NORMAL C1 INH ANTIGENIC PROTEIN LEVELS OR FUNCTION LEVELS

AGE RESTRICTION
MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
If being used for prophylaxis: documentation that medication is not being used in combination with another prophylactic human C1 esterase inhibitor (Haegarda), berotralstat (Orladeyo) or lanadelumab (Takhzyro) therapy for hereditary angioedema. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

CLOLAR(GHP)

MEDICATION(S)
CLOFARABINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RELAPSED OR REFRACTORY ACUTE LYMPHOBLASTIC LEUKEMIA

AGE RESTRICTION
1 TO 21 YEARS OF AGE

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PRIOR TREATMENT REGIMENS. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

CLOMIPRAMINE HRM(GHP)

MEDICATION(S)
CLOMIPRAMINE HCL 25 MG CAP, CLOMIPRAMINE HCL 50 MG CAP, CLOMIPRAMINE HCL 75 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: FLUOXETINE, FLUVOXAMINE, SERTRALINE

COLUMVI(GHP)

MEDICATION(S)
COLUMVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED, OR LARGE B-CELL LYMPHOMA (LBCL) ARISING FROM FOLLICULAR LYMPHOMA AND DOCUMENTATION OF PRIOR THERAPY WITH AT LEAST TWO LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 6 MONTHS CONTINUATION

OTHER CRITERIA
ONE TIME REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. TREATMENT WITH COLUMVI SHOULD NOT EXCEED THE FDA-APPROVED TREATMENT DURATION OF 12 MONTHS. REQUESTS EXCEEDING 12 MONTHS WILL REQUIRE DOCUMENTATION OF PEER REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

COMETRIQ(GHP)

MEDICATION(S)
COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PROGRESSIVE METASTATIC MEDULLARY THYROID CANCER

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

COPIKTRA(GHP)

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of one of the following: Relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to at least two prior therapies. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

CORLANOR(GHP)

MEDICATION(S)
CORLANOR 5 MG TAB, CORLANOR 7.5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF STABLE, SYMPTOMATIC HEART FAILURE WITH A LEFT VENTRICULAR EJECTION FRACTION LESS THAN OR EQUAL TO 35% AND DOCUMENTATION OF BEING IN SINUS RHYTHM WITH RESTING HEART RATE GREATER THAN OR EQUAL TO 70 BEATS PER MINUTE AND DOCUMENTATION OF HOSPITALIZATION FOR WORSENING HEART FAILURE WITHIN THE PREVIOUS 12 MONTHS. DOCUMENTATION OF STABLE, SYMPTOMATIC HEART FAILURE DUE TO DILATED CARDIOMYOPATHY and DOCUMENTATION OF CLASS II TO IV HEART FAILURE ACCORDING TO NYHA FUNCTIONAL CLASS OR ROSS CLASSIFICATIONS and DOCUMENTATION OF A LEFT VENTRICULAR EJECTION FRACTION LESS THAN OR EQUAL TO 45% and DOCUMENTATION OF BEING IN SINUS RHYTHM WITH RESTING HEART RATE GREATER THAN OR EQUAL TO THE LOWER LIMIT OF THE NORMAL RANGE BASED ON AGE

AGE RESTRICTION
HF with EF less than 35%: 18 years of age or older. HF due to cardiomyopathy: 6 months of age or older

PRESCRIBER RESTRICTION
CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THE MAXIMUM TOLERATED

DOSES OF TWO FORMULARY BETA-BLOCKERS ONE OF WHICH MUST BE CARVEDILOL

COSELA(GHP)

MEDICATION(S)
COSELA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF EXTENSIVE-STAGE SMALL CELL LUNG CANCER (ES-SCLC) AND DOCUMENTATION THAT MEMBER IS CURRENTLY TAKING A PLATINUM/ETOPOSIDE-CONTAINING REGIMEN OR TOPOTECAN-CONTAINING REGIMEN.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A

COSENTYX IV(GHP)

MEDICATION(S)
COSENTYX 125 MG/5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ANKYLOSING SPONDYLITIS. DIAGNOSIS OF MODERATE TO SEVERE ACTIVE PERIPHERAL OR AXIAL PSORIATIC ARTHRITIS WITH A HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS. DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS. DOCUMENTATION OF ONE OF THE FOLLOWING: C-REACTIVE PROTEIN (CRP) LEVEL ABOVE THE UPPER LIMIT OF NORMAL (10 MG/DL) OR SACROLIITIS ON MAGNETIC RESONANCE IMAGING (MRI).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. DOCUMENTATION THAT THE PRESCRIBED DOSE IS APPROPRIATE FOR PATIENTS WEIGHT AND DOES NOT EXCEED 300MG PER INFUSION. FOR AS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE

FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR NR-AXSPA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

COSENTYX(GHP)

MEDICATION(S)
COSENTYX 150 MG/ML SOLN PRSYR, COSENTYX 75 MG/0.5ML SOLN PRSYR, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ANKYLOSING SPONDYLITIS. DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS CHARACTERIZED BY GREATER THAN 5% OF BSA INVOLVED OR DISEASE INVOLVING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS. DIAGNOSIS OF MODERATE TO SEVERE ACTIVE PERIPHERAL OR AXIAL PSORIATIC ARTHRITIS WITH A HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS. DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS. DOCUMENTATION OF ONE OF THE FOLLOWING: C-REACTIVE PROTEIN (CRP) LEVEL ABOVE THE UPPER LIMIT OF NORMAL (10 MG/DL) OR SACROLIITIS ON MAGNETIC RESONANCE IMAGING (MRI). DIAGNOSIS OF ENTHESITIS-RELATED ARTHRITIS. DIAGNOSIS OF MODERATE TO SEVERE HIDRADENITIS SUPPURATIVA (HS), DEFINED AS STAGE II OR III ON THE HURLEY STAGING SYSTEM.

AGE RESTRICTION
FOR HS: 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR AS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE OR PHOTOTHERAPY. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR NR-AXSPA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR ENTHESITIS RELATED ARTHIRITIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR PSORIASIS, PSORIATIC ARTHRITIS, AND ENTHESITIS RELATED ARTHRITIS: DOCUMENTATION THAT THE PRESCRIBED DOSE IS APPROPRIATE FOR PATIENTS WEIGHT. FOR HS: DOCUMENTATION OF AT LEAST 3 ABSECESSES OR INFLAMMATORY NODULES. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

COTELLIC(GHP)

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND DOCUMENTATION OF BRAF V600E OR V600K MUTATION AS DETECTED BY AN FDA APPROVED TEST. DOCUMENTATION OF CONCOMITANT USE WITH VEMURAFENIB. 2)Diagnosis of histiocytic neoplasm (Langerhans Cell Histiocytosis, Rosai-Dorfman Disease, Erdheim-Chester Disease, Xanthogranuloma, Mixed Histiocytosis).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST, or DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

CRINONE(GHP)

MEDICATION(S)
CRINONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of secondary amenorrhea

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Failure on, intolerance to, or contraindication to medroxyprogesterone

CRIZOTINIB(GHP)

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) THAT IS ANAPLASTIC LYMPHOMA KINASE (ALK) POSITIVE AS DETECTED BY AN FDA APPROVED TEST or DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) THAT IS ROS 1-POSITIVE. Diagnosis of relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is anaplastic lymphoma kinase (ALK) positive AND documentation of at least one prior systemic treatment. DIAGNOSIS OF UNRESECTABLE, RECURRENT, OR REFRACTORY INFLAMMATORY MYOFIBROBLASTIC TUMOR (IMT) THAT IS ALK POSITIVE.

AGE RESTRICTION
FOR IMT ONLY: MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR ALK-POSITIVE, METASTATIC NON-SMALL CELL LUNG CANCER: DOCUMENTATION OF RATIONALE FOR NOT TREATING WITH ALECENSA IF CLINICALLY APPROPRIATE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

CRYSVITA(GHP)

MEDICATION(S)
CRYSVITA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF X-LINKED HYPOPHOSPHATEMIA AS EVIDENCED BY ONE OF THE FOLLOWING: REDUCED TMP/GFR RATIO WITH EITHER REDUCED PLASMA CONCENTRATION OF 1,25-DIHYDROXYCHOLECALCIFEROL (1,25-DHCC) OR 25-HYDROXYVITAMIN D (25(OH)D) OR GENETIC TESTING CONFIRMING A MUTATION IN THE PHEX (PHOSPHATE REGULATING ENDOPEPTIDASE ON THE X CHROMOSOME) GENE. DIAGNOSIS OF FGF23-RELATED HYPOPHOSPHATEMIA IN TUMOR-INDUCED OSTEOMALACIA (TIO) ASSOCIATED WITH PHOSPHATURIC MESENCHYMAL TUMORS AND DOCUMENTATION OF AN ELEVATED SERUM LEVEL OF FGF23 AND DOCUMENTATION THAT THE TUMOR CANNOT BE CURATIVELY RESECTED OR LOCALIZED.

AGE RESTRICTION
TIO:2 YEARS OR OLDER. X-LINKED:6 MONTHS OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, NEPHROLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
DOCUMENTATION THAT THE MEMBER IS NOT CURRENTLY USING ACTIVE VITAMIN D ANALOGS OR PHOSPHATE SUPPLEMENTS. SUBSEQUENT APPROVALS WILL REQUIRE

DOCUMENTATION OF CONTINUED FOLLOW UP AND DETERMINATION OF MEDICAL NECESSITY FROM AN ENDOCRINOLOGIST, NEPHROLOGIST OR ONCOLOGIST AND DOCUMENTATION OF IMPROVING PATIENT'S DISEASE AS EVIDENCED BY NORMALIZED OR IMPROVED SERUM PHOSPHORUS LEVELS AND DOCUMENTATION THAT PATIENT IS NOT USING ACTIVE VITAMIN D ANALOGS OR PHOSPHATE SUPPLEMENTS

CUVRIOR(GHP)

MEDICATION(S)
CUVRIOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF WILSON'S DISEASE AND DOCUMENTATION OF CONTROLLED WILSON'S DISEASE AS EVIDENT BY SERUM NON-CERULOPLASMIN COPPER (NCC) LEVEL BETWEEN 25 AND 150 MCG/L AND DOCUMENTATION THAT MEMBER IS TOLERANT TO PENICILLAMINE AND THAT PENICILLAMINE WILL BE DISCONTINUED PRIOR TO THERAPY WITH WITH CUVRIOR.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TRIENTINE.

CYCLOSET(GHP)

MEDICATION(S)
CYCLOSET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TYPE 2 DIABETES MELLITUS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO ORAL FORMULARY ANTIDIABETIC AGENTS.

CYPROHEPTADINE HRM(GHP)

MEDICATION(S)
CYPROHEPTADINE HCL 2 MG/5ML SYRUP, CYPROHEPTADINE HCL 4 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF ALLERGIC CONDITIONS PRURITUS, URTICARIA, SEASONAL OR PERENNIAL ALLERGIES) WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DESLORATADINE AND LEVOCETIRIZINE.

CYRAMZA(GHP)

MEDICATION(S)
CYRAMZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF ADVANCED OR METASTATIC, GASTRIC, OR GASTRO-ESOPHAGEAL JUNCTION ADENOCARCINOMA WITH DISEASE PROGRESSION ON OR AFTER PRIOR FLUOROPYRIMIDINE OR PLATINUM CONTAINING CHEMOTHERAPY. DOCUMENTATION OF USE IN COMBINATION WITH PACLITAXEL OR CLINICAL JUSTIFICATION FOR USE AS MONOTHERAPY. DIAGNOSIS OF METASTATIC NON SMALL CELL LUNG CANCER WITH EITHER 1)IN COMBINATION WITH DOCETAXEL IN THOSE WITH DISEASE PROGRESSION ON OR AFTER PLATINUM BASED CHEMOTHERAPY AND PATIENTS WITH EGFR OR ALK GENOMIC TUMOR ABERRATIONS MUST PROVIDE DOCUMENTATION OF DISEASE PROGRESSION ON FDA APPROVED THERAPIES FOR THESE ABERRATIONS PRIOR TO RECEIVING CYRAMZA OR 2) USED IN COMBINATION WITH ERLOTINIB AS FIRST LINE TREATMENT WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OR EXON 21 (L858R) MUTATIONS. DOCUMENTATION OF METASTATIC COLON OR RECTAL CANCER WITH DISEASE PROGRESSION ON OR AFTER FOLFOX, CAPEOX OR A REGIMEN NOT PREVIOUSLY CONTAINING IRINOTECAN AND DOCUMENTATION OF USE IN COMBINATION WITH IRINOTECAN OR FOLFIRI (FLUOROURACIL, LEUCOVORIN, AND IRINOTECAN). DOCUMENTATION OF HEPATOCELLULAR CARCINOMA AND DOCUMENTATION OF AN ALPHA FETOPROTEIN (AFP) LEVEL OF 400 NG/ML OR GREATER AND DOCUMENTATION OF DISEASE PROGRESSION ON OR AFTER TREATMENT WITH SORAFENIB OR AN INTOLERANCE TO SORAFENIB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

DALIRESP(GHP)

MEDICATION(S)
ROFLUMILAST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF COPD ASSOCIATED WITH CHRONIC BRONCHITIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
CONCOMITANT USE OF, FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 1) SPIRIVA or INCRUSE ELLIPTA AND 2) ONE LONG ACTING BETA AGONISTS.

DALVANCE(GHP)

MEDICATION(S)
DALVANCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACUTE BACTERIAL SKIN AND SOFT TISSUE INFECTION CAUSED BY ONE OF THE FOLLOWING SUSCEPTIBLE MICROORGANISMS: Staphylococcus aureus (including methicillin-susceptible and methicillin-resistant isolates), Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus dysgalactiae, Streptococcus anginosus group (including S. anginosus, Streptococcus intermedius, Streptococcus constellatus), OR Enterococcus faecalis (vancomycin-susceptible isolates).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
8 DAYS

OTHER CRITERIA
DOCUMENTATION OF A CULTURE AND SENSITIVITY SHOWING THE PATIENTS INFECTION IS NOT SUSCEPTIBLE TO ALTERNATIVE ANTIBIOTICS TREATMENTS OR A DOCUMENTED HISTORY OF PREVIOUS INTOLERANCE TO OR CONTRAINDICATION TO TWO OTHER ANTIBIOTICS SHOWN TO BE SUSCEPTIBLE ON THE CULTURE AND SENSITIVITY.

DANYELZA(GHP)

MEDICATION(S)
DANYELZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY HIGH-RISK NEUROBLASTOMA IN THE BONE OR BONE MARROW WHO HAVE DEMONSTRATED A PARTIAL RESPONSE, MINOR RESPONSE OR STABLE DISEASE TO PRIOR THERAPY AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH GRANULOCYTE-MACROPHAGE COLONY STIMULATING FACTOR (GM-CSF).

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

DARAPRIM(GHP)

MEDICATION(S)
PYRIMETHAMINE 25 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of toxoplasmosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
3 MONTHS INITIAL, 6 MONTHS CONTINUATION

OTHER CRITERIA
Documentation of use in combination with leucovorin and a sulfonamide OR therapeutic failure on, intolerance to or contraindication to a sulfonamide. Reauthorization will require documentation of clinical syndrome (such as headache or other neurological symptom) OR documentation of persistent radiographic disease.

DARZALEX FASPRO(GHP)

MEDICATION(S)
DARZALEX FASPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA (MM). FOR NEWLY DIAGNOSED MM: DOCUMENTATION OF EITHER 1)NOT BEING ELIGIBLE FOR STEM CELL TRANSPLANTATION (I.E. COEXISTING CONDITIONS, AGE GREATER THAN 65, ETC) AND DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBINATION WITH ONE OF THE FOLLOWING: BORTEZOMIB, MELPHALAN AND PREDNISONE (VMP) OR LENALIDOMIDE AND DEXAMETHASONE OR 2) DOCUMENTATION THAT MEMBER IS ELIGIBLE FOR STEM-CELL TRANSPLANTATION AND DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBINATION WITH BORTEZOMIB, THALIDOMIDE, AND DEXAMETHASONE (DVTD). FOR RELAPSED OR REFRACTORY MM: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST THREE PRIOR LINES OF THERAPY INCLUDING A PROTEASOME INHIBITOR (INCLUDING BUT NOT LIMITED TO VELCADE, KYPROLIS OR NINLARO) AND AN IMMUNOMODULATORY AGENT (INCLUDING BUT NOT LIMITED TO POMALYST, REVLIMID OR THALOMID) OR DOCUMENTATION THAT THE MEMBER IS DOUBLE-REFRACTORY TO A PROTEASOME INHIBITOR AND AN IMMUNOMODULATORY AGENT OR DOCUMENTATION OF USE IN COMBINATION WITH POMALIDOMIDE AND DEXAMETHASONE WITH DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO AT LEAST ONE PRIOR LINE OF THERAPY INCLUDING LENALIDOMIDE AND A PROTEOSOME INHIBITOR OR DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST 1 PRIOR THERAPY INCLUDING A PROTEASOME INHIBITOR OR AN IMMUNOMODULATORY AGENT AND ONE OF THE FOLLOWING: DOCUMENTATION OF USE IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE, OR IN COMBINATION WITH BORTEZOMIB AND DEXAMETHASONE OR IN COMBINATION WITH CARFILZOMIB AND

DEXAMETHASONE. DOCUMENTATION OF LIGHT-CHAIN AMYLOIDOSIS USED IN COMBINATION WITH BORTEZOMIB, CYCLOPHOSPHAMIDE AND DEXAMETHASONE.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR LIGHT-CHAIN AMYLOIDOSIS: DOCUMENTATION THAT MEMBER DOES NOT HAVE NEW YORK HEART ASSOCIATION (NYHA) CLASS IIIB OR CLASS IV HEART FAILURE OR MAYO CARDIAC STAGE IIIB. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

DARZALEX(GHP)

MEDICATION(S)
DARZALEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA (MM). FOR NEWLY DIAGNOSED MM: DOCUMENTATION OF EITHER 1)NOT BEING ELIGIBLE FOR STEM CELL TRANSPLANTATION (I.E. COEXISTING CONDITIONS, AGE GREATER THAN 65, ETC) AND DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBINATION WITH ONE OF THE FOLLOWING: BORTEZOMIB, MELPHALAN AND PREDNISONE (VMP) OR LENALIDOMIDE AND DEXAMETHASONE OR 2) DOCUMENTATION THAT MEMBER IS ELIGIBLE FOR STEM-CELL TRANSPLANTATION AND DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBINATION WITH BORTEZOMIB, THALIDOMIDE, AND DEXAMETHASONE (DVTD). FOR RELAPSED OR REFRACTORY MM: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST THREE PRIOR LINES OF THERAPY INCLUDING A PROTEASOME INHIBITOR (INCLUDING BUT NOT LIMITED TO VELCADE, KYPROLIS OR NINLARO) AND AN IMMUNOMODULATORY AGENT (INCLUDING BUT NOT LIMITED TO POMALYST, REVLIMID OR THALOMID) OR DOCUMENTATION THAT THE MEMBER IS DOUBLE-REFRACTORY TO A PROTEASOME INHIBITOR AND AN IMMUNOMODULATORY AGENT OR DOCUMENTATION OF USE IN COMBINATION WITH POMALIDOMIDE AND DEXAMETHASONE FOLLOWING A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST 2 PRIOR LINES OF THERAPY INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR OR DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST 1 PRIOR THERAPY INCLUDING A PROTEASOME INHIBITOR OR AN IMMUNOMODULATORY AGENT AND ONE OF THE FOLLOWING: DOCUMENTATION OF USE IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE, OR IN COMBINATION WITH BORTEZOMIB AND DEXAMETHASONE OR IN COMBINATION WITH CARFILZOMIB AND DEXAMETHASONE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

DAURISMO(GHP)

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of newly diagnosed acute myeloid leukemia (AML) AND documentation of age greater than or equal to 75 years or documentation of a comorbidity that precludes use of intensive induction chemotherapy AND documentation of use in combination with low-dose cytarabine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Subsequent approval after 12 months will require documentation of continued disease improvement or lack of disease progression.

DAYBUE(GHP)

MEDICATION(S)
DAYBUE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CLASSIC, OR TYPICAL, RETT SYNDROME AND DOCUMENTATION OF MECP2 GENE MUTATION.

AGE RESTRICTION
2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
3 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF PATIENT BASELINE SYMPTOMS USING AS APPROPRIATE RATING SCALE (E.G., RETT SYNDROME BEHAVIORAL QUESTIONNAIRE, SIMPLIFIED SEVERITY SCORE, CLINICAL GLOBAL IMPRESSION-IMPROVEMENT ASSESSMENT) AND DOCUMENTATION THAT MEMBER IS RECEIVING AN APPROPRIATE DOSE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CLINICAL IMPROVEMENT IN RETT SYNDROME SYMPTOMS AS MEASURED BY AN APPROPRIATE RATING SCALE (COMPARED TO PREVIOUS MEASUREMENT)

DEMSER(GHP)

MEDICATION(S)
METYROSINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TREATMENT OF PHEOCHROMOCYTOMA PREOPERATIVELY. TREATMENT OF PHEOCHROMOCYTOMA IN MANAGEMENT OF PATIENTS WHEN SURGERY IS CONTRAINDICATED. CHRONIC TREATMENT OF MALIGNANT PHEOCHROMOCYTOMA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

DIACOMIT(GHP)

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Dravet syndrome AND documentation that medication is to be used in combination with clobazam AND documentation of weight greater than or equal to 7 kg.

AGE RESTRICTION
MUST BE 6 MONTHS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation wih a neurologist

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

DICLEGIS(GHP)

MEDICATION(S)
DOXYLAMINE-PYRIDOXINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF NAUSEA AND VOMITING OF PREGNANCY IN ADULT WOMEN

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
9 MONTHS

OTHER CRITERIA
N/A

DIFICID(GHP)

MEDICATION(S)
DIFICID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED DIAGNOSIS OF C. DIFFICILE INFECTION (CDI).

AGE RESTRICTION
6 MONTHS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
10 DAYS

OTHER CRITERIA
DOCUMENTATION OF AN APPROPIATE DOSE AND DURATION OF THERAPY. DOCUMENTATION OF ONE OF THE FOLLOWING: 1) THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VANCOMYCIN, OR 2) DOCUMENTATION THAT MEMBER IS AT HIGH RISK FOR TREATMENT FAILURE WITH VANCOMYCIN (I.E., DUE TO A MEDICAL CONDITION SUCH AS COMPROMISED IMMUNITY), OR 3) DOCUMENTATION OF CONTINUED THERAPY UPON INPATIENT DISCHARGE, OR 4) DOCUMENTATION OF BEING USED FOR TREATMENT OF A RECURRENT C. DIFFICILE INFECTION.

DOJOLVI(GHP)

MEDICATION(S)
DOJOLVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) confirmed by at least two of the following, (1) Disease specific elevation of acylcarnitines on a newborn blood spot or in plasma, (2) Low enzyme activity in cultured fibroblasts, (3) One or more known pathogenic mutations in a gene associated with a long-chain fatty acid oxidation disorder (e.g., CPT2, ACADVL, HADHA, or HADHB)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
by or in consultation with a metabolic specialist or a physician who specializes in the management of long-chain fatty acid oxidation disorders

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

DOPTELET(GHP)

MEDICATION(S)
DOPTELET 20MG TAB, DOPTELET TAB 40MG DAILY DOSE PACK, DOPTELET TAB 60MG DAILY DOSE PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF THROMBOCYTOPENIA IN ADULT PATIENTS WITH CHRONIC LIVER DISEASE AND DOCUMENTATION OF A PLATELET COUNT LESS THAN 50 X 1000000000 (10 TO THE 9TH POWER)/L MEASURED WITHIN THE PAST 30 DAYS. DOCUMENTATION OF A PLANNED INVASIVE PROCEDURE TO BE PERFORMED 10 TO 13 DAYS AFTER INITIATION OF TREATMENT. DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA AND DOCUMENTATION OF A PLATELET COUNT LESS THAN 30,000/MICROL.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a hematologist, gastroenterologist, hepatologist, immunologist, transplant specialist, interventional radiologist, endocrinologist, or surgeon

COVERAGE DURATION
pre-procedure:30 DAYS. Chronic ITP 3 months initial, 12 months reauth

OTHER CRITERIA
Documentation that the member is not receiving other TPO-Ras (i.e. romiplostin, eltrombopag). For pre-procedure of thrombocytopenia with chronic liver disease: Documentation that the correct dose of medication is being used based on the platelet count (platelet count 40-50 x 1000000000 (10 TO THE 9TH POWER)/L: 40 mg once daily for 5 consecutive days, platelet count less than 40 x 1000000000

(10 TO THE 9TH POWER)/L,000: 60 mg once daily for 5 consecutive days). For chronic ITP: documentation of a therapeutic failure on one previous treatment, including, but not limited to: corticosteroids, IVIG, Rhogam (if RhD-positive and spleen intact), Rituximab, splenectomy, eltrombopag or romiplostim. Subsequent approval after 3 months will require documentation of medical necessity such as a platelet count necessary to reduce the risk for bleeding OR a hematological response.

DRIZALMA(GHP)

MEDICATION(S)
DRIZALMA SPRINKLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ONE OF THE FOLLOWING: MAJOR DEPRESSIVE DISORDER, DIABETIC PERIPHERAL NEUROPATHIC PAIN, CHRONIC MUSCULOSKELETAL PAIN, FIBROMYALGIA, OR GENERALIZED ANXIETY DISORDER

AGE RESTRICTION
For GAD: 7 years of age or older. All others: 18 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF DIFFICULTY SWALLOWING OR DOCUMENTATION OF ADMINISTRATION OF MEDICATION THROUGH A NASOGASTRIC TUBE OR DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DULOXETINE CAPSULES.

DRONABINOL(GHP)

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHEMOTHERAPY INDUCED NAUSEA AND VOMITING or DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CHEMOTHERAPY INDUCED NAUSEA AND VOMITING: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO ANTIEMETIC THERAPIES, ONE OF WHICH MUST BE A 5HT3 ANTAGONIST. FOR ANOREXIA: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO MEGESTEROL ACETATE.

DUAVEE(GHP)

MEDICATION(S)
DUAVEE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF AN INTACT UTERUS. DOCUMENTATION OF USE FOR ABNORMAL VASOMOTOR FUNCTION OR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR ABNORMAL VASOMOTOR FUNCTION: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FEMRING. FOR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: ALENDRONATE, IBANDRONATE, RALOXIFENE, RISEDRONATE.

DUPIXENT(GHP)

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of moderate to severe atopic dermatitis. Documentation of either oral corticosteroid dependent asthma OR moderate to severe eosinophilic asthma with a blood eosinophilic count greater than or equal to 150 cells/microL. For asthma, documentation that medication will be used as an add-on maintenance treatment. Diagnosis of add-on maintenance treatment of inadequately controlled chronic rhino-sinusitis with nasal polyps (CRwNP). Diagnosis of eosinophillic esophagitis. Diagnosis of prurigo nodularis.

AGE RESTRICTION
ATOPIC DERMATITIS: 6 MONTHS OR OLDER. ASTHMA: 6 YRS OR OLDER. CRwNP and EOSINOPHILLIC ESOPHAGITIS: 12 YRS OR OLDER. PRURIGO NODULARIS: 18 YRS OR OLDER

PRESCRIBER RESTRICTION
MUST BE PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST, DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST, GASTROENTEROLOGIST OR OTOLARYNGOLOGIST (ENT provider)

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS RENEWAL

OTHER CRITERIA
FOR ATOPIC DERMATITIS: DOCUMENTATION OF FAILURE ON EITHER DAILY TREATMENT WITH AT LEAST MEDIUM POTENCY TOPICAL CORTICOSTEROID OR TOPICAL CALCINEURIN INHIBITOR (I.E. TACROLIMUS) IF TOPICAL CORTICOSTEROIDS ARE NOT ADVISABLE. FOR

ASTHMA, DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH BENRALIZUMAB, MEPOLIZUMAB, OMALIZUMAB, RESLIZUMAB, OR TEZEPELUMAB AND DOCUMENTATION OF ONE OF THE FOLLOWING: A CONTRAINDICATION, INTOLERANCE TO, OR POORLY CONTROLLED SYMPTOMS DESPITE AT LEAST A 3-MONTH TRIAL OF MAXIMALLY TOLERATED INHALED CORTICOSTEROIDS OR ORAL SYSTEMIC CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST OR DOCUMENTATION OF ONE EXACERBATION IN THE PREVIOUS 12 MONTHS REQUIRING ADDITIONAL MEDICAL TREATMENT DESPITE CURRENT THERAPY OR INTOLERANCE TO INHALED CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST. FOR CRWNP: CHRONIC RHINOSINUSITIS IS DEFINED AS NASAL MUCOSAL INFLAMMATION WHICH PERSISTS FOR 12 WEEKS OR LONGER. DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO INTRANASAL CORTICOSTEROIDS. DOCUMENTATION THAT MEDICATION WILL BE USED AS ADD ON THERAPY (I.E. WITH INTRANASAL CORTICOSTEROIDS OR OTHER THERAPY). FOR EOSINOPHILLIC ESOPHAGITIS: DOCUMENTATION OF MEMBER WEIGHT GREATER THAN OR EQUAL TO 40 KG. DOCUMENTATION OF 15 OR MORE INTRAEPITHELIAL EOSINOPHILS PER HIGH POWER FIELD (eos/hpf). DOCUMENTATION OF CONTRAINDICATION TO, INTOLERANCE TO, THERAPEUTIC FAILURE ON A PROTON PUMP INHIBITOR OR A REASON WHY A PROTON PUMP INHIBITOR COULD NOT BE TRIED. DOCUMENTATION THAT MEMBER IS EXPERIENCING CHRONIC SYMPTOMS OF ESOPHAGEAL DYSFUNCTION (such as but not limited to, i.e., dysphagia, food impaction, abdominal pain, heartburn). FOR PRURIGO NODULARIS: DOCUMENTATION OF FAILURE ON TWO VERY HIGH-POTENCY TOPICAL CORTICOSTEROIDS (such as but not limited to betamethasone diproprionate, clobetasol or halobetasol). REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND (FOR CRWNP), DOCUMENTATION THAT MEDICATION CONTINUES TO BE USED AS ADD ON THERAPY.

ELAPRASE(GHP)

MEDICATION(S)
ELAPRASE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HUNTER'S SYNDROME (MPS II)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR GENETICIST WITH EXPERIENCE TREATING MPS II

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

ELELYSO(GHP)

MEDICATION(S)
ELELYSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TYPE 1 GAUCHER DISEASE WITH AT LEAST ONE OF THE FOLLOWING - ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST, GENETICIST OR HEMATOLOGIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ELFABRIO(GHP)

MEDICATION(S)
ELFABRIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FABRY DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST WITH EXPERIENCE TREATING FABRY DISEASE

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ELIDEL(GHP)

MEDICATION(S)
PIMECROLIMUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ATOPIC DERMATITIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TACROLIMUS OINTMENT AND ONE FORMULARY TOPICAL CORTICOSTEROID UNLESS INADVISABLE DUE TO RISKS (SUCH AS USE ON SENSITIVE SKIN AREAS (FACE, AXILLAE, GROIN))

ELITEK(GHP)

MEDICATION(S)
ELITEK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HYPERURICEMIA IN PATIENTS WITH LEUKEMIA, LYMPHOMA, AND SOLID TUMOR MALIGNANCIES

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
1 COURSE OF THERAPY (5 DAYS)

OTHER CRITERIA
DOCUMENTATION OF A HIGH RISK OF TUMOR LYSIS SYNDROME CHARACTERIZED BY ELEVATED SERUM CREATININE OR LEUKEMIAS WITH VERY HIGH WHITE BLOOD CELL COUNTS OF GREATER THAN OR EQUAL TO 25,000 / MM(3) OR BURKITT'S LYMPHOMA OR T-CELL NON-HODGKIN'S LYMPHOMA OR SERUM URIC ACID LEVEL GREATER THAN OR EQUAL TO 8 MG/DL AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ORAL OR INJECTABLE ALLOPURINOL

ELREXFIO(GHP)

MEDICATION(S)
ELREXFIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA AND DOCUMENTATION OF TREATMENT WITH AT LEAST 4 PRIOR LINES OF THERAPY, INCLUDING A PROTEASOME INHIBITOR, AN IMMUNOMODULATORY AGENT, AND AN ANTI-CD38 MONOCLONAL ANTIBODY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

EMEND(GHP)

MEDICATION(S)
APREPITANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CHEMOTHERAPY REGIMEN WITH MODERATE TO HIGH EMETOGENIC POTENTIAL OR INDICATION OF POSTOPERATIVE NAUSEA/VOMITING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST, SURGEON

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MUST BE USED IN COMBINATION WITH OTHER ORAL ANTIEMETIC AGENTS WHEN USED FOR THE PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA

EMFLAZA(GHP)

MEDICATION(S)
DEFLAZACORT, EMFLAZA 22.75 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF DUCHENNE MUSCULAR DYSTROPHY CONFIRMED BY GENETIC TESTING

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST OR PEDIATRIC NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PREDNISONE

EMGALITY(GHP)

MEDICATION(S)
EMGALITY, EMGALITY (300 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of migraine with or without aura AND documentation of the number of baseline migraine or headache days per month. Diagnosis of episodic cluster headache, based on the ICHD-III diagnostic criteria AND documentation of the number of baseline cluster headache attack frequency AND documentation that member is currently experiencing a cluster headache period (period of recurrent attacks).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MIGRAINE:6 MONTHS INITIAL, 1 YEAR CONTINUATION. CLUSTER HA:6 MONTHS

OTHER CRITERIA
Migraine: provider attestation of a therapeutic failure on, intolerance to, or contraindication to at least two of the following: one beta blocker (i.e., metoprolol, propranolol, timolol, atenolol, nadolol), topiramate, divalproex or sodium valproate, amitriptyline, or venlafaxine. Attestation that medication is not being used concurrently with botulinum toxin OR if being used in combination, attestation of the following: therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND attestation of a therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist. Attestation that medication will not be used

concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine. Reauthorization will require attestation of continued or sustained reduction in migraine or headache frequency or a decrease in severity or duration of migraine AND either attestation that the medication is not being used concurrently with botulinum toxin OR if the request is for combination use with Botox attestation of the following: previous therapeutic failure on a minimum 3 month trial of at least one CGRP antagonist without the concomitant use of Botox AND attestation of a previous therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist AND Attestation that medication will not be used concomitantly with another CGRP receptor antagonist indicated for the preventive treatment of migraine. Cluster HA: Documentation of a therapeutic failure on, intolerance to, or contraindication to verapamil. Reauthorization for use for cluster headaches will require a diagnosis of episodic cluster headache, based on the ICHD-III diagnostic criteria AND documentation that the member is currently experiencing a cluster headache period (period of recurrent attacks) AND documentation of continued or sustained reduction in cluster headache attack frequency.

EMPAVELI(GHP)

MEDICATION(S)
EMPAVELI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF DIAGNOSIS CONFIRMED BY FLOW CYTOMETRY. DOCUMENTATION THAT MEMBER HAS RECEIVED VACCINATIONS AGAINST ENCAPSULATED BACTERIA, INCLUDING STREPTOCOCCUS PNEUMONIAE, NEISSERIA MENINGITIDIS, AND HAEMOPHILUS INFLUENZA TYPE B. DOCUMENTATION OF ONE OF THE FOLLOWING:1)MEMBER IS TRANSFUSION-DEPEDENT PRIOR TO STARTING THERAPY (I.E., HAS AT LEAST 1 TRANSFUSION IN THE 24 MONTHS PRIOR TO INITIATION OF MEDICATION DUE TO HEMOGLOBIN LESS THAN 7 G/DL IN PERSONS WITHOUT ANEMIC SYMPTOMS OR LESS THAN 9 G/DL IN PERSONS WITH SYMPTOMS FROM ANEMIA) OR 2) THERE IS SIGNIFICANT ADVERSE IMPACT ON MEMBERS HEALTH SUCH AS END ORGAN DAMAGE OR THROMBOSIS WITHOUT OTHER CAUSE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF HEMOLYSIS CONTROL MEASURED BY LACTIC ACID DEHYDROGENASE (LDH) LEVEL LESS THAN 1.5 TIMES

THE UPPER LIMIT OF NORMAL AND REDUCED NEED OR ELIMINATION OF TRANSFUSION REQUIREMENTS OR STABILIZATION OF HEMOGLOBIN LEVELS.

EMPLICITI(GHP)

MEDICATION(S)
EMPLICITI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA AND DOCUMENTATION OF ONE OF THE FOLLOWING: 1) DOCUMENTATION THAT MEMBER HAS PREVIOUSLY BEEN TREATED WITH AT LEAST ONE PRIOR THERAPY FOR MULTIPLE MYELOMA AND THAT THE MEDICATION IS BEING USED IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE OR 2) DOCUMENTATION THAT THE MEMBER HAS PREVIOUSLY BEEN TREATED WITH AT LEAST TWO PRIOR THERAPIES FOR MULTIPLE MYELOMA AND THAT MEDICATION IS BEING USED IN COMBINATION WITH POMALIDOMIDE AND DEXAMETHASONE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 6 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ENBREL(GHP)

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ADULT RA - DIAGNOSIS OF RA MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. PJIA - DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATE TO SEVERE PSA AND DOCUMENTATION OF ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS. DIAGNOSIS OF PERIPHERAL PSA OR DIAGNOSIS OF AXIAL PSA. ANKYLOSING SPONDYLITIS - DIAGNOSIS OF ANKYLOSING SPONDYLITIS. PLAQUE PSORIASIS - DIAGNOSIS OF MODERATE TO SEVERE ADULT OR PEDIATRIC PLAQUE PSORIASIS WITH GREATER THAN OR EQUAL TO 5% OF BSA INVOLVED OR DISEASE INVOLVING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE OR GENITALS. DIAGNOSIS OF MODERATE TO SEVERE JUVENILE PSORIATIC ARTHRITIS (JPsA).

AGE RESTRICTION
JIA AND JPsA: MUST BE AT LEAST 2 YEARS OF AGE, PP: MUST BE AT LEAST 4 YEARS OF AGE, ALL OTHERS: MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF

BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE DISEASE MODIFYING ANTI-RHEUMATIC DRUG (DMARD), SUCH AS BUT NOT LIMITED TO METHOTREXATE, LEFLUNOMIDE OR SULFASALAZINE. FOR JIA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND ONE OF THE FOLLOWING DMARDS: LEFLUNOMIDE OR METHOTREXATE. FOR PERIPHERAL PSA AND JPSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA AND JPSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR JPSA: DOCUMENTATION THAT PRESCRIBED DOSE IS APPROPRIATE FOR PATIENT'S WEIGHT. FOR AS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE OR PHOTOTHERAPY. FOR PEDIATRIC PLAQUE PSORIASIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TWO FORMULARY TOPICAL CORTICOSTEROIDS. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ENDARI(GHP)

MEDICATION(S)
ENDARI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of sickle cell disease AND documentation of being used to reduce the acute complications of sickle cell disease.

AGE RESTRICTION
MUST BE 5 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to hydroxyurea. Reauthorization will require documentation of continued or sustained improvement in the acute complications of sickle cell disease (i.e. number of sickle cell crises, hospitalizations or number of acute chest syndrome occurrences)

ENHERTU(GHP)

MEDICATION(S)
ENHERTU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC HER2-POSITIVE BREAST CANCER AND DOCUMENTATION OF ONE OF THE FOLLOWING: 1)DOCUMENTATION OF PRIOR ANTI-HER2 BASED THERAPY IN THE METASTATIC SETTING OR 2)DOCUMENTATION OF PRIOR ANTI-HER2 BASED THERAPY IN THE NEOADJUVANT SETTING AND DOCUMENTATION OF DISEASE RECURRENCE DURING OR WIHTIN 6 MONTHS OF COMPLETING THERAPY. DIAGNOSIS OF UNRESECTABLE OR METASTATIC HER2-LOW (IHC 1+ OR IHC2+/ISH-) BREAST CANCER, AS DETECTED BY AN FDA APPROVED TEST, USED AS A SINGLE AGENT AND DOCUMENTATION OF ONE OF THE FOLLOWING 1) DOCUMENTATION OF PRIOR CHEMOTHERAPY IN THE METASTATIC SETTING OR 2) DOCUMENTATION OF DISEASE RECURRENCE DURING OR WITHIN 6 MONTHS OF COMPLETING ADJUVANT CHEMOTHERAPY. DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC HER2-POSITIVE GASTRIC OR GASTROESOPHAGEAL JUNCTION (GEJ) ADENOCARCINOMA AND DOCUMENTATION OF ONE OR MORE PRIOR TRASTUZUMAB BASED THERAPIES. DOCUMENTATION OF USE AS A SINGLE AGENT FOR UNRESECTABLE OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AND DOCUMENTATION OF TUMORS THAT HAVE ACTIVATING HER2 (ERBB2) MUTATIONS AS DETECTED BY AN FDA APPROVED TEST AND DOCUMENTATION OF TREATMENT WITH PRIOR SYSTEMIC THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ENSPRYNG(GHP)

MEDICATION(S)
ENSPRYNG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of Neuromyelitis Optica Spectrum Disorder (NMOSD) AND documentation that member is anti-aquaporin-4 (AQP4) antibody positive.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with a neurologist or ophthalmologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ENTYVIO(GHP)

MEDICATION(S)
ENTYVIO 108 MG/0.68ML SOLN PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of moderate to severe ulcerative colitis.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR UC: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS, AMINOSALICYLATES OR IMMUNOMODULATORS (I.E. 6-MERCAPTOPURINE OR AZATHIOPRINE). FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

EPCLUSA(GHP)

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CRITERIA (INDICATION, DOSING, ETC.) WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. MEDICAL RECORD DOCUMENTATION OF A DIAGNOSIS OF HEPATITIS C INFECTION WITH IDENTIFICATION OF GENOTYPE AND SUBTYPE. DOCUMENTATION OF METAVIR LIVER FIBROSIS OR CIRRHOSIS ASSESSMENT BY A NON-INVASIVE TEST. DOCUMENTATION OF PREVIOUS TREATMENT AND TREATMENT RESPONSE. DOCUMENTATION OF RECEIVING THE FOLLOWING WITHIN THE PAST 6 MONTHS:HEPATIC FUNCTION PANEL, COMPLETE BLOOD COUNT, BASIC METABOLIC PANEL. DOCUMENTATION OF A BASELINE HCV RNA VIRAL LOAD. DOCUMENTATION OF NO LIMITED LIFE EXPECTANCY OF LESS THAN 12 MONTHS DUE TO NON LIVER RELATED COMORBID CONDITIONS.

AGE RESTRICTION
MUST BE 3 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BOARD CERTIFIED GASTROENTEROLOGIST, HEPATOLOGIST, INFECTIOUS DISEASE SPECIALIST OR TRANSPLANT SPECIALIST

COVERAGE DURATION
PER AASLD/IDSA GUIDELINES

OTHER CRITERIA
Documentation of any potential drug interactions that may impact drug therapy addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or

counseling of the risks associated with the use of both medications when they interact). Documentation of either 1) completed hepatitis B series OR 2) Hepatitis B screening (sAb/sAg and cAb/cAg) and quantitative hepatitis B virus (HBV) DNA if positive for hepatitis B sAg or cAb or cAg AND either documentation of treatment for Hepatitis B if there is detectable hepatits B virus OR documentation of being vaccinated against Hepatitis B if negative for hepatitis B sAb. Documentation of intolerance to, contraindication to, or therapeutic failure of Mavyret, if appropriate.

EPIDIOLEX(GHP)

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of Lennox-Gastaut syndrome, Dravet syndrome or seizures associated with tuberous sclerosis complex.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For Lennox-Gastaut Syndrome: documentation of a therapeutic failure on, intolerance to, or contraindication to two formulary anticonvulsants used for the requested diagnosis.

EPKINLY(GHP)

MEDICATION(S)
EPKINLY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED, INCLUDING DLBCL ARISING FROM INDOLENT LYMPHOMA AND DOCUMENTATION OF PRIOR THERAPY WITH AT LEAST TWO LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

EPOETIN(GHP)

MEDICATION(S)
EPOGEN, PROCRIT, RETACRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TX OF ANEMIA OF CHRONIC KIDNEY DISEASE. TX OF ANEMIA IN NON-MYELOID MALIGNANCY - MUST BE ON ANEMIA CAUSING CHEMO AND THERE IS A MINIMUM OF TWO ADDITIONAL MONTHS OF PLANNED CHEMO. TX OF ANEMIA IN ZIDOVUDINE TREATED HIV INFECTED INDIVIDUAL AND ENDOGENOUS EPO LEVELS OF 500 MU/ML OR LESS and ZIDOVUDINE DOSES OF 4200 MG OR LESS PER WEEK. REDUCTION OF ALLOGENEIC BLOOD TRANSFUSION IN ANEMIC INDIVIDUAL UNDERGOING ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY IN WHICH ANTICIPATED BLOOD LOSS IS GREATER THAN 2 UNITS AND THE NEED FOR ALLOGENEIC BLOOD TRANSFUSION IS ANTICIPATED. FOR CRF NOT ON DIALYSIS AND CANCER: HEMOGLOBIN (HGB) MUST BE LESS THAN OR EQUAL TO 10GM/DL FOR NEW STARTS or LESS THAN 10 GM/DL FOR CONTINUATION OF THERAPY OR DOCUMENTATON THAT THE DOSE WILL BE REDUCED OR INTERRUPTED FOR CKD ON DIALYSIS HEMOGLOBIN (HGB) MUST BE LESS THAN OR EQUAL TO 10GM/DL FOR NEW STARTS or LESS THAN 11 GM/DL FOR CONTINUATION OF THERAPY OR DOCUMENTATON THAT THE DOSE WILL BE REDUCED OR INTERRUPTED FOR SURGERY INDICATION: HGB MUST BE LESS THAN 13 G/DL. FOR ALL OTHER INDICATIONS: HGB MUST BE LESS THAN OR EQUAL TO 10GM/DL FOR NEW STARTS or LESS THAN 12 GM/DL FOR CONTINUATION OF THERAPY. FOR ALL INDICATIONS: DOCUMENTATION OF ADEQUATE IRON STORES W/ SERUM FERRITIN GREATER THAN 100 NG/ML OR TRANSFERRIN LEVEL SATURATION GREATER THAN 20% OR A HISTORY OF CHELATION THERAPY FOR IRON.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

FOR SURGICAL INDICATION: 3 MONTHS. ALL OTHER INDICATIONS 12 MONTHS

OTHER CRITERIA

NON MYELOID MALIGNANCIES INCLUDE ALL TYPES OF CARCINOMA, SARCOMA, MELANOMA, MULTIPLE MYELOMA, LYMPHOMA, AND LYMPHOCYTIC LEUKEMIA. REAUTHORIZATION WILL REQUIRE REPEAT HGB (WITHIN 3 MONTHS OF REAUTH) AND FERRITIN OR TSAT LEVELS (WITHIN 6 MONTHS OF REAUTH). THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EPOPROSTENOL(GHP)

MEDICATION(S)
EPOPROSTENOL SODIUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL RECORD DOCUMENTATION OF A DIAGNOSIS OF CLASS II OR HIGHER PULMONARY ARTERIAL HYPERTENSION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CLASS 2 OR 3 PAH: MEDICAL RECORD DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL

EPRONTIA(GHP)

MEDICATION(S)
EPRONTIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PARTIAL ONSET SEIZURES, PRIMARY GENERALIZED TONIC-CLONIC SEIZURES, OR LENNOX GASTUAT SYNDROME. DOCUMENTATION OF A DIAGNOSIS OF USE FOR MIGRAINE PROPHYLAXIS.

AGE RESTRICTION
SEIZURES: 2 YRS OF AGE OR OLDER. MIGRAINES: 12 YRS OR AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES USED FOR THE TREATMENT OF ASSOCIATED DIAGNOSIS, ONE OF WHICH MUST BE TOPIRAMATE IR TABLETS OR TOPIRAMATE IR SPRINKLE CAPSULE OR DOCUMENTATION OF DIFFICULTY SWALLOWING TABLETS AND THERAPEUTIC FAILURE ON OR INTOLERANCE TO TWO FORMULARY ALTERNATIVES USED FOR THE TREATMENT OF ASSOCIATED DIAGNOSIS, ONE OF WHICH MUST BE TOPIRAMATE IR SPRINKLE CAPSULES

ERAXIS(GHP)

MEDICATION(S)
ERAXIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
NON-NEUTROPENIC PATIENT WITH DX OF CANDIDEMIA OR OTHER CANDIDA INFECTION (OTHER THAN ENDOCARDITIS, OSTEOMYELITIS OR MENINGITIS).

AGE RESTRICTION
1 MONTH OF AGE OR OLDER

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
8 WEEKS (TWO COURSES OF THERAPY)

OTHER CRITERIA
FOR A DIAGNOSIS OF ESOPHAGEAL CANDIDIASIS - FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FLUCONAZOLE THERAPY

ERIVEDGE(GHP)

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC BASAL CELL CARCINOMA, OR LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING SURGERY OR FOR PATIENTS WHO ARE NOT CANDIDATES FOR SURGERY, AND WHO ARE NOT CANDIDATES FOR RADIATION.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PER NCCN GUIDELINES, TREATMENT SUPPORTED BY MULTIDISCIPLINARY BOARD CONSULTATION OR A SECOND DERMATOLOGIST OR ONCOLOGIST. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ERLEADA(GHP)

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of prostate cancer with evidence of metastatic castration-sensitive disease OR diagnosis of non-metastatic prostate cancer AND documentation that member is no longer responding to castration or is hormone resistant

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR documentation of bilateral orchiectomy. Reauthorizations will require documentation of continued disease improvement or lack of disease progression.n.

ESBRIET(GHP)

MEDICATION(S)
PIRFENIDONE 267 MG CAP, PIRFENIDONE 267 MG TAB, PIRFENIDONE 801 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF IDIOPATHIC PULMONARY FIBROSIS (IPF) CONFIRMED BY EITHER A USUAL INTERSTITIAL PNEUMONIA PATTERN ON HIGH RESOLUTION CT SCAN OR BOTH HRCT AND SURGICAL LUNG BIOPSY PATTERN SUGGESTIVE OF IPF OR PROBABLE IPF MADE BY AN INTERDISCIPLINARY TEAM INCLUDING, BUT NOT LIMITED TO SPECIALISTS FROM PULMONARY MEDICINE, RADIOLOGY, THORACIC SURGERY, PATHOLOGY OR RHEUMATOLOGY AND DOCUMENTATION THAT THERE ARE NO OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE SUCH AS DOMESTIC AND OCCUPATIONAL ENVIRONMENTAL EXPOSURES, CONNECTIVE TISSUE DISEASE OR DRUG TOXICITY AND DOCUMENTATION THAT THE PATIENT WAS TAUGHT PULMONARY REHABILITATION TECHNIQUES

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

ESOMEPRAZOLE PACKETS(GHP)

MEDICATION(S)
ESOMEPRAZOLE MAGNESIUM 10 MG PACKET, ESOMEPRAZOLE MAGNESIUM 20 MG PACKET, ESOMEPRAZOLE MAGNESIUM 40 MG PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of an FDA approved indication

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to lansoprazole ODT. Documentation of one of the following: (1) documentation that member has difficulty swallowing or has a NG tube OR (2) documentation of therapeutic failure on, intolerance to, or contraindication to esomeprazole capsules.

EUCRISA(GHP)

MEDICATION(S)
EUCRISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of mild to moderate atopic dermatitis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MUST BE PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of contraindication to, intolerance to, or therapeutic failure on tacrolimus ointment for members 2 years of age and older. Documentation of contraindication to, intolerance to, or therapeutic failure on at least one formulary topical corticosteroid unless deemed inadvisable due to potential risks such as use on sensitive skin areas (face, axillae, or groin).

EVENITY(GHP)

MEDICATION(S)
EVENITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of postmenopausal osteoporosis AND documentation that member has not previously received greater than or equal to 12 monthly doses of Evenity. Documentation that the patient is at high-risk of a fracture, determined by the presence of one or more of the following: 1) previous osteoporotic fracture, 2)spine or hip DXA T-Score of -2.5 or below, 3)FRAX calculation of the 10-year hip fracture risk of 3% or greater, 4)FRAX calculation of the 10-year risk of major osteoporotic fractures of 20% or greater or 5) documentation that the patient has failed or is intolerant to at least one prior osteoporosis therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, ENDOCRINOLOGIST, INTERNIST AND ORTHOPEDIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that the patient has not had a myocardial infarction or stroke within the past 12 months.

EVKEEZA(GHP)

MEDICATION(S)
EVKEEZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AND DOCUMENATION OF USE AS ADJUNCTIVE THERAPY WITH OTHER LOW-DENSITY LIPOPROTEIN-CHOLESTEROL (LDL-C) LOWERING THERAPIES. DOCUMENTATION OF EITHER (1) GENETIC TESTING TO CONFIRM DIAGNOSIS SHOWING A MUTATION IN THE LOW-DENSITY LIPOPROTEIN (LDL) RECEPTOR (LDLR) GENE, APOLIPOPROTEIN B (APOB) GENE, PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) GENE OR LDL PROTEIN RECEPTOR 1 ADAPTOR 1 (LDLRAP1) GENE OR (2) DIAGNOSIS MADE BASED ON HISTORY OF AN UNTREATED LOW-DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) GREATER THAN 500 MG/DL AND EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) IN BOTH PARETNS.

AGE RESTRICTION
MUST BE AT LEAST 5 YEARS OF AGE

PRESCRIBER RESTRICTION
LIDIPOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF FAILURE TO ADEQUATELTY CONTROL LDL LEVELS WITH A MAXIMUM TOLERATED STATIN THERAPY (IF STATIN TOLERANT) TO LESS THAN 130 MG/DL IN

PEDIATRIC PATIENTS 5 TO 18 YEARS OF AGE OR LESS THAN 100 MG/DL IN ADULTS WITHOUT CVD OR LESS THAN 70 MG/DL IN ADULTS WITH ESTABLISHED CVD. FOR PATIENTS 10 YEARS AND OLDER: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO EVOLOCUMAB (REPATHA). FOR PATIENTS 18 YEARS AND OLDER: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO EVOLOCUMAB (REPATHA) OR ALIROCUMAB (PRAULENT). FOR REQUESTS FOR USE IN COMBINATION WITH JUXTAPID: DOCUMENTATION OF FAILURE TO ADEQUATELY CONTROL LDL LEVELS WITH A MINIMUM 6-MONTH TRIAL OF MAXIMUM TOLERATED JUXTAPID DOSE WITHOUT CONCOMIITANT USE OF EVKEEZA. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF MEDICAL NECESSITY AND THAT THERAPY WITH EVKEEZA IS EFFECTIVE.

EVRYSDI(GHP)

MEDICATION(S)
EVRYSDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of 5q Spinal Muscular Atrophy (SMA) confirmed by genetic testing with either one of the following: 1)Homozygous exon 7 gene deletion, 2) Homozygous exon 7 conversion mutation OR 3) compound heterozygous exon 7 mutation OR documentation of diagnostic testing confirming zero SMN1 copies

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR PEDIATRIC NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that patient has not received prior treatment with gene therapy (such as, but not limited to Zolgensma) AND documentation that member will not receive routine concomitant SMN modifying therapy (such as, but not limited to Spinraza). Reauthorization will require documentation of medical necessity AND documentation that member has not received prior treatment with gene therapy AND documentation that memer will not receive routine concomitant SMN modifying therapy.

EXJADE(GHP)

MEDICATION(S)
DEFERASIROX 125 MG TAB SOL, DEFERASIROX 250 MG TAB SOL, DEFERASIROX 500 MG TAB SOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis) OR diagnosis of chronic iron overload caused by non-transfusion dependent thalassemia

AGE RESTRICTION
for tranfusional hemosiderosis: must be 2 years of age or older. For non-transfusional dependent thalassemia: must be 10 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
For transfusional hemosiderosis: documentation of a serum ferritin level greater than 1000 MCG/L. Continuation of coverage requires documentation of a serum ferritin greater than 500 MCG/L, but decreased from baseline. For non-transfusion dependent thalassemia: documentation of LIC (liver iron concentration) greater than 5 milligrams of iron per gram of dry liver tissue weight (FE/Gdw) AND serum ferritin greater than 300 MCG/L. Continuation of coverage requires documentation of a serum ferritin level greater than 300 MCG/L, but decreased from baseline.

EXKIVITY(GHP)

MEDICATION(S)
EXKIVITY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AND DOCUMENTATION OF DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY AND DOCUMENTATION OF EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATION, AS DETECTED BY AN FDA APPROVED TEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

EXONDYS(GHP)

MEDICATION(S)
EXONDYS 51

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF DUCHENNE'S MUSCULAR DYSTROPHY CONFIRMED BY GENETIC TESTING WITH MUTATION OF THE DMD GENE THAT IS AMENABLE BY EXON 51 SKIPPING AND DOCUMENTATION THAT MEDICATION IS BEING GIVEN CONCURRENTLY WITH ORAL CORTICOSTEROIDS AND DOCUMENTATION THAT THE PATIENT IS AMBULATORY (ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND) AS PROVEN BY DOCUMENTATION OF A 6-MINUTE WALK TEST DISTANCE WITHIN THE PAST 3 MONTHS OF INITIATION OF EXONDYS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR GENETIC SPECIALIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE CONTINUED CONCURRENT USE WITH ORAL CORTICOSTEROIDS AND DOCUMENTATION THAT THE PATIENT REMAINS AMBULATORY AS PROVEN BY DOCUMENTATION OF A FOLLOW UP 6 MINUTE WALK TEST DISTANCE WITHIN THE PAST 6 MONTHS

EXSERVAN(GHP)

MEDICATION(S)
EXSERVAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of ALS (amyotrophic lateral sclerosis)

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to riluzole tablets OR documentation that the patient has dysphagia or is unable to swallow tablets.

FABRAZYME(GHP)

MEDICATION(S)
FABRAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF FABRY DISEASE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST WITH EXPERIENCE TREATING FABRY DISEASE

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

FARYDAK(GHP)

MEDICATION(S)
FARYDAK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA AND DOCUMENTATION OF BEING USED IN COMBINATION WITH VELCADE AND DEXAMETHASONE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND CONTINUATION. MAXIMUM OF 12 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BORTEZOMIB AND AN IMMUNOMODULATORY AGENT (INCLUDING, BUT NOT LIMITED TO POMALYST, REVLIMID, THALOMID)

FASENRA(GHP)

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of severe eosinophilic asthma AND documentation that medication is being used as add-on maintenance treatment. Documentation of a blood eosinophil count of 150 cell/mcL or greater within 3 months of starting therapy.

AGE RESTRICTION
Must be 12 years of age or older

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF CONTRAINDICATION, INTOLERANCE TO, OR POORLY CONTROLLED SYMPTOMS DESPITE AT LEAST A 3-MONTH TRIAL OF MAXIMALLY TOLERATED INHALED CORTICOSTEROIDS AND/OR ORAL SYSTEMIC CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST OR ONE EXACERBATION IN THE PREVIOUS 12 MONTHS REQUIRING ADDITIONAL MEDICAL TREATMENT (ORAL CORTICOSTEROIDS, EMERGENCY DEPARTMENT OR URGENT CARE VISTIS, OR HOSPITALIZATION) DESPITE CURRENT THERAPY OR INTOLERANCE TO INHALED CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST AND DOCUMENTATION THAT FASENRA IS NOT BEING USED IN COMBINATION WITH DUPILUMAB, OMALIZUMAB, MEPOLIZUMAB, TEZEPELUMAB OR RESLIZUMAB. DOCUMENTATION OF A

THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO NUCALA. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

FENSOLVI(GHP)

MEDICATION(S)
FENSOLVI (6 MONTH)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CENTRAL PRECOCIOUS PUBERTY

AGE RESTRICTION
2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PEDIATRIC ENDOCRINOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO , OR CONTRAINDICATION TO LUPRON DEPOT-PED AND TRIPTODUR.

FERRIC CITRATE(GHP)

MEDICATION(S)
AURYXIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
This medication requires payment determination

FERRIPROX(GHP)

MEDICATION(S)
DEFERIPRONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF TRANSFUSIONAL IRON OVERLOAD DUE TO ONE OF THE FOLLOWING: 1)THALASSEMIA SYNDROMES or 2) SICKLE CELL DISEASE OR OTHER ANEMIAS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO EXJADE. DOCUMENTATION OF ANC GREATER THAN 1.5 X 1000000000 (10 TO THE 9TH POWER)/L. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF SERUM FERRITIN LEVEL GREATER THAN 300 MCG/L.

FETROJA(GHP)

MEDICATION(S)
FETROJA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF COMPLICATED URINARY TRACT INFECTION, INCLUDING PYELONEPHRITIS CAUSED BY THE FOLLOWING SUCEPTIBLE GRAM NEGATIVE MICROORGANISMS: ESCHERICHIA COLI, KLEBSIELLA PENUMONIAE, PROTEUS MIRABILIS, PSEUDOMONAS AERUGINOSA, OR ENTEROBACTER CLOACAE COMPLEX. DOCUMENTATION OF HOSPITAL ACQUIRED BACTERIAL PNEUMONIA (HABP) OR VENTILATOR ASSOCIATED BACTERIAL PNEUMONIA (VABP) CAUSED BY THE FOLLOWING SUSCEPTIBLE GRAM NEGATIVE MICROORGANISMS: ACINETOBACTER BAUMANNII COMPLEX, ESCHERICHIA COLI, KLEBSIELLA PENUMONIAE, PSEUDOMONAS AERUGINOSA, SERRATIA MARCESCENS , OR ENTEROBACTER CLOACAE COMPLEX.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA
DOCUMENTATION OF A CULTURE AND SENSITIVITY SHOWING THE PATIENT'S INFECTION IS NOT SUSCEPTIBLE TO PREFERRED ALTERNATIVE ANTIBIOTICS TREATMENTS OR A DOCUMENTED HISTORY OF PREVIOUS INTOLERANCE TO OR CONTRAINDICATION TO TWO

OTHER ANTIBIOTICS SHOWN TO BE SUSCEPTIBLE ON THE CULTURE AND SENSITIVITY.

FETZIMA(GHP)

MEDICATION(S)
FETZIMA, FETZIMA TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES.

FILSPARI (GHP)

MEDICATION(S)
FILSPARI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PRIMARY IMMUNOGLOBULIN 1 NEPHROPATHY (IgAN) VERIFIED BY BIOPSY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEPHROLOGIST

COVERAGE DURATION
9 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT MEMBER IS AT HIGH RISK OF DISEASE PROGRESSION AND DOCUMENTATION OF EGFR GREATER THAN OR EQUAL TO 30 ML/MIN/1.73M2 AND DOCUMENTATION THAT MEMBER HAS RECEIVED A STABLE DOSE OF A RAS INHIBITOR AT A MAXIMALLY TOLERATED DOSE FOR AT LEAST 90 DAYS AND DOCUMENTATION THAT RAS INHIBITORS WILL BE DISCONTINUED PRIOR TO INITIATION OF TREATMENT WITH FILSPARI AND DOCUMENTATION THAT FILSPARI WILL NOT BE USED IN COMBINATION WITH ANY RAS INHIBITORS, ENDOTHELIN RECEPTOR ANTAGONISTS, OR ALISKIREN. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION ACCORDING TO PRESCRIBER (I.E., DECREASED LEVELS OF PROTEINURIA FROM BASELINE OR DECREASED UPCR FROM BASELINE) AND

DOCUMENTATION THAT FILSPARI WILL NOT BE USED IN COMBINATION WITH ANY RAS INHIBITORS, ENDOTHELIN RECEPTOR ANTAGONISTS, OR ALISKIREN.

FINTEPLA(GHP)

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF DRAVET SYNDROME OR A DIAGNOSIS OF LENNOX-GASTAUT SYNDROME

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR DRAVET SYNDROME: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES USED FOR THE TREATMENT OF DRAVET SYNDROME, INCLUDING BUT NOT LIMITED TO CANNABIDIOL, CLOBAZAM, VALPROATE, AND TOPIRAMATE. FOR LENNOX-GASTAUT SYNDROME: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES USED FOR THE TREATMENT OF LENNOX-GASTAUT SYNDROME, INCLUDING BUT NOT LIMITED TO CANNABIDIOL, CLOBAZAM, LAMOTRIGINE, FELBAMATE, CLONAZEPAM, RUFINIMIDE AND TOPIRAMATE.

FIRAZYR(GHP)

MEDICATION(S)
ICATIBANT ACETATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HEREDITARY ANGIOEDEMA AND DOCUMENATION OF THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDEMA WITHOUT URTICARIA SUPPORTED BY DOCUMENTATION OF TWO OR MORE SETS OF COMPLEMENT STUDIES, SEPARATED BY ONE MONTH OR MORE SHOWING LOW C4 LEVELS AND LESS THAN 50 PERCENT OF THE LOWER LIMIT OF NORMAL C1 INH ANTIGENIC PROTEIN LEVELS OR FUNCTION LEVELS.

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST, OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
DOCUMENTATION THAT ICATIBANT IS BEING USED FOR TREATMENT OF ACUTE HEREDITARY ANGIOEDEMA ATTACK. DOCUMENTATION THAT ICATIBANT IS NOT BEING USED IN COMBINATION WITH OTHER APPROVED TREATMENTS FOR ACUTE HAE ATTACKS. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

FIRDAPSE(GHP)

MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Lambert-Eaton Myasthenic Syndrome confirmed by one of the following: post-exercise facilitation test showing increase in compound muscle action potential (CMAP) amplitude of at least 60 percent compared to pre-exercise baseline value OR high-frequency Repetitive Nerve Stimulation (RNS) showing increase in compound muscle action potential (CMAP) of at least 60 percent OR positive anti-P/Q type voltage-gated calcium channel antibody test.

AGE RESTRICTION
MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION or PRESCRIBER ATTESTATION OF MEDICAL NECESSITY AND THAT THE MEMBER WILL BENEFIT FROM CONTINUED THERAPY.

FLECTOR(GHP)

MEDICATION(S)
DICLOFENAC EPOLAMINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF USE FOR THE TREATMENT OF ACUTE PAIN DUE TO MINOR STRAINS, SPRAINS, CONTUSIONS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 WEEKS

OTHER CRITERIA
N/A

FORTEO(GHP)

MEDICATION(S)
TERIPARATIDE, TERIPARATIDE (RECOMBINANT)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PRIMARY, HYPOGONADAL, OR GLUCOCORTICOID INDUCED OSTEOPOROSIS IN MALES or POSTMENOPAUSAL or GLUCOCORTICOID INDUCED OSTEOPOROSIS IN FEMALES. DOCUMENTATION THAT MEMBER HAS NOT PREVIOUSLY BEEN ON A PARATHYROID HORMONE ANALOG FOR GREATER THAN 2 YEARS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 MONTHS

OTHER CRITERIA
DOCUMENTATION OF AN ATTEMPT OF THERAPY WITH OR CONTRAINDICATION TO BISPHOSPHONATES or EITHER A PREVIOUS OSTEOPOROTIC FRACTURE OR HIGH RISK OF FRACTURE (T-SCORE LESS THAN -2.5 WITH DOCUMENTED RISK FACTORS).

FOTIVDA(GHP)

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of relapsed or refractory advanced renal cell cancer following two or more prior systemic therapies.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

FRUZAQLA(GHP)

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF METASTATIC COLORECTAL CANCER (mCRC) AND DOCUMENTATION OF PREVIOUS TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY, AN ANTI-VEGF BIOLOGICAL THERAPY, AND IF RAS WILD-TYPE, AN ANTI-EGFR THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

FYARRO(GHP)

MEDICATION(S)
FYARRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED UNRESECTABLE OR METASTATIC MALIGNANT PERIVASCULAR EPITHELIOID CELL TUMOR (PEComa).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

FYCOMPA(GHP)

MEDICATION(S)
FYCOMPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES OR PRIMARY GENERALIZED TONIC-CLONIC SEIZURES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: carbamazepine, divalproex, valproic acid, felbamate, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, zonisamide, Lyrica, Sabril, Aptiom, Vimpat

FYLNETRA(GHP)

MEDICATION(S)
FYLNETRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE, BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY

TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CrcL LESS THAN 50 ML/MIN).

GALAFOLD(GHP)

MEDICATION(S)
GALAFOLD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Fabry disease as confirmed by one of the following: Enzyme assay indicating deficiency of Alpha Gal-A (if male) OR genetic test documenting galactosidase alpha gene mutation. Documentation of in vitro assay data confirming the presence of an amenable galactosidase alpha gene (GLA) variant, in accordance with the FDA-approved prescribing information.

AGE RESTRICTION
MUST BE 16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with a geneticist, nephrologist, cardiologist or a specialist with experience treating Fabry disease

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
Documentation that medication is not being used concurrently with enzyme replacement therapy intended for the treatment of Fabry disease, such as agalsidase beta. Reauthorization will require medical record documentation of clinical improvement or lack of progression in signs and symptoms of Fabry disease while on therapy.

GAMIFANT(GHP)

MEDICATION(S)
GAMIFANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PRIMARY HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS (HLH) BASED ON ONE OF THE FOLLOWING: 1) A MOLECULAR DIAGNOSIS (HLH GENE MUTATIONS) OR 2) A FAMILY HISTORY CONSISTENT WITH PRIMARY HLH (X-LINKED LYMPHOPROLIFERATIVE SYNDROME) OR 3) FULLFILLMENT OF AT LEAT 5 OF THE FOLLOWING CRITERIA: FEVER GREATER THAN 38.5C, SPLENOMEGALY (CYTOPENIAS AFFECTING 2 OF 3 LINEAGES IN THE PERIPHERAL BLOOD (HEMOGLOBIN LESS THAN 9 G/DL, PLATELETS LESS THAN 100X10 TO THE 9TH/L, NEUTROPHILS LESS THAN 1X10 TO THE 9TH/L)), HYPERTRIGLYCERIDEMIA (FASTING TRIGLYCERIDES GREATER THAN 3 MMOL/L OR GREATER THAN 265 MG/DL AND/OR HYPERFIBRINOGENEMIA (LESS THAN OR EQUAL TO 1.5 G/DL)), HEMOPHAGOCYTOSIS IN BONE MARROW, SPLEEN, OR LYMPH NODES WITH NO EVIDENCE OF MALIGNANCY, LOW OR ABSENT NK-CELL ACTIVITY, FERRITIN GREATER THAN OR EQUAL TO 500 MCG/L, SOLUBLE CD25 LEVEL (I.E. SOLUBLE IL-2 RECEPTOR) OR GREATER THAN OR EQUAL TO 2400 U/ML.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
UNCONFIRMED MOLECULAR DX: 4 WEEKS. CONFIRMED DX: 6 MONTHS. 6 MONTH REAUTH

OTHER CRITERIA

DOCUMENTATION OF REFRACTORY, RECURRENT OR PRORESSIVE DISEASE OR INTOLERANCE WITH CONVENTIONAL HLH THERAPY (SUCH AS, BUT NOT LIMITED TO ETOPOSIDE, DEXAMETHASONE, CYCLOSPORINE A, INTRATHECAL METHOTREXATE). REAUTHORIZATION WITHOUT A CONFIRMED MOLECULAR DIAGNOSIS WILL REQUIRE DOCUMENTATION OF PRIMARY HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS BASED ON MOLECULAR DIAGNOSIS (HLH MUTATION) AND DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REAUTHORIZATION FOLLOWING A CONFIRMED MOLECULAR DIAGNOSIS WILL REQUIE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

GATTEX(GHP)

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SHORT BOWEL SYNDROME

AGE RESTRICTION
MUST BE AT LEAST 1 YEAR OF AGE

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FOR PATIENTS 1 THROUGH 17 YEARS OF AGE: DOCUMENTATION THAT THE MEMBER IS DEPENDENT ON PARENTERAL NUTRITION/INTRAVENOUS SUPPORT. FOR PATIENTS 18 YEARS AND OLDER: DOCUMENTATION THAT THE MEMBER HAS BEEN DEPENDENT ON PARENTERAL NUTRITION/INTRAVENOUS SUPPORT FOR A MINIMUM OF 12 MONTHS CONTINUOUSLY AND THAT THE MEMBER REQUIRES PARENTERAL NUTRITION AT LEAST 3 TIMES PER WEEK. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CLINICAL IMPROVEMENT SUCH BUT NOT LIMITED TO A DECREASE OF PARENTERAL NUTRITION/INTRAVENOUS SUPPORT, ENTERAL AUTONOMY, OR REDUCTION IN PARENTERAL SUPPORT INFUSION.

GAVRETO(GHP)

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of metastatic non-small cell lung cancer (NSCLC) AND documentation of a rearranged during transfection (RET)-fusion positive tumor as detected by an FDA approved test. Documentation of either 1)advanced metastatic RET-mutant medullary thyroid cancer (MTC) AND documentation that sytemic therapy is required OR 2)documentation of advanced metastatic RET fusion-positive thryoid cancer AND documentation that systemic therapy is required AND documentation that patient is radioactive-iodine refractory when radioactive iodine is appropriate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

GAZYVA(GHP)

MEDICATION(S)
GAZYVA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA WHICH IS PREVIOUSLY UNTREATED OR DIAGNOSIS OF FOLLICULAR LYMPHOMA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
CLL: 12 MONTHS. FOLLICULAR LYMPHOMA: 6 MONTHS INITIAL, 24 MONTHS REAUTH

OTHER CRITERIA
FOR CLL: DOCUMENTATION OF BEING USED IN COMBINATION WITH CHLORAMBUCIL. FOR FOLLICULAR LYMPHOMA: DOCUMENTATION OF PREVIOUSLY UNTREATED STAGE II BULKY, III OR IV DISEASE USED IN COMBINATION WITH CHEMOTHERAPY, OR AS MONOTHERAPY FOLLOWING AT LEAST A PARTIAL REMISSION IF PREVIOUSLY TREATED WITH AT LEAST 6 CYCLES OF GAZYVA IN COMBINATION WITH CHEMOTHERAPY. FOR SECOND LINE FOLLICULAR LYMPHOMA: DOCUMENTATION OF BEING USED IN COMBINATION WITH BENDAMUSTINE, OR AS MONOTHERAPY IF PREVIOUSLY TREATED WITH 6 CYCLES IN COMBINATION WITH BENDAMUSTINE AND DOCUMENTATION THAT PATIENT RELAPSED AFTER, OR IS REFRACTORY TO A RITUXIMAB CONTAINING REGIMEN. REAUTH FOR FOLLICULAR LYMPHOMA AFTER INITIAL 6 MONTHS WILL REQUIRE DOCUMENTATION OF A

COMPLETE RESPONSE, PARTIAL RESPONSE, OR HAS STABLE DISEASE AND THAT MEDICATION IS BEING USED AS MONOTHERAPY. SUBSEQUENT APPROVAL FOR CLL WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

GCSF LA(GHP)

MEDICATION(S)
NYVEPRIA, UDENYCA, ZIEXTENZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME. Documentation of Hematopoietic syndrome of Acute Radiation Syndrome (HSARS) with documentation of an acute exposure to myelosuppressive doses of radiation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
HSARS: 14 days. All others: 6 months.

OTHER CRITERIA
ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE,

BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CRCL LESS THAN 50 ML/MIN).

GCSF(GHP)

MEDICATION(S)
NIVESTYM, RELEUKO, ZARXIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME. FOR STEM CELL TRANSPLANTATION WHEN ONE OF THE FOLLOWING IS MET: DOCUMENTATION OF NON-MYELOID MALIGNANCY UNDERGOING MYELOABLATIVE CHEMOTHERAPY FOLLOWED BY AUTOLOGOUS OR ALLOGENIC BONE MARROW TRANSPLANTATION or USED FOR MOBILIZATION OF AUTOLOGOUS HEMATOPOIETIC PROGENITOR CELLS INTO THE PERIPHERAL BLOOD FOR COLLECTION BY LEUKAPHARESIS. AML RECEIVING INDUCTION OR CONSOLIDATION THERAPY. FOR SEVERE CHRONIC NEUTROPENIA WHEN THE FOLLOWING ARE MET: DX OF CONGENITAL, CYCLIC OR IDIOPATHIC NEUTROPENIA and ABSOLUTE NEUTROPHIL COUNT IS LESS THAN 500 CELLS/MM3 ON THREE SEPARATE OCCASIONS DURING A 6 MONTH PERIOD OR FIVE CONSECUTIVE DAYS OF ANC LESS THAN 500 CELLS/MM3 PER CYCLE and DOCUMENTATION OF INFECTION, FEVER OR OROPHARYNGEAL ULCER DURING THE PAST 12 MONTHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE, BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CrcL LESS THAN 50 ML/MIN).

GEMTESA(GHP)

MEDICATION(S)
GEMTESA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF OVERACTIVE BLADDER (OAB).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO USE OF TWO FORMULARY AGENTS FOR THE TREATMENT OF OAB, ONE OF WHICH MUST BE MIRABEGRON.

GILOTRIF(GHP)

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF FIRST LINE TREATMENT FOR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE NON-RESISTANT EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST or DOCUMENTATION OF A DIAGNOSIS OF METASTATIC, SQUAMOUS NON-SMALL CELL LUNG CANCER (NSCLC) WHICH HAS PROGRESSED AFTER PLATINUM BASED CHEMOTHERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

GIVLAARI(GHP)

MEDICATION(S)
GIVLAARI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF ACUTE HEPATIC PORPHYRIA (AHP), INCLUDING ACUTE INTERMITTENT PORPHYRIA (AIP), HEREDITARY COPROPORPHYRIA (HCP), VARIEGATE PORPHYRIA (VP), AND AMINOLEVULINIC ACID DEHYDRATASE (ALAD) PORPHYRIA (ADP) CONFIRMED MY AT LEAST ONE OF THE FOLLOWING: 1)ELEVATED URINARY OR PLASMA AMINOLEVULINIC ACID (ALA) OR 2)ELEVATED URINARY OR PLASMA PORPHOBILINOGEN (PBG) OR 3) GENETIC TESTING CONFIRMING A MUTATION ASSOCIATED WITH ACUTE HEPATIC PORPHYRIA (AHP).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
SPECIALIST WITH EXPERIENCE MANAGING PORPHYRIAS (I.E., HEMATOLOGIST, HEPATOLOGIST OR GASTROENTEROLOGIST)

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
DOCUMENTATION OF THE BASELINE NUMBER OF PORPHYRIA ATTACKS REQUIRING HOSPITALIZATION, URGENT HEALTHCARE VISIT, OR IV HEMIN TREATMENT WITHIN THE PREVIOUS 6 MONTHS AND DOCUMENTATION OF ACTIVE DISEASE WITH AT LEAST TWO DOCUMENTED PORPHYRIA ATTACKS WITH THE PREVIOUS 6 MONTHS. REUATHORIZATION WILL REQUIRE DOCUMENTATION OF A CLINICALLY SIGNIFICANT RESPONSE TO TREATMENT

AS EVIDENCED BY: 1) A REDUCTION IN THE NUMBER OF PORPHYRIA ATTACKS REQUIRING HOSPITALIZATION, URGENT HEALTHCARE VISIT, OR IV HEMIN TREATMENT WITHIN THE PREVIOUS 6 MONTHS FROM BASELINE OR 2) DECREASED SEVERITY IN THE SYMPTOMS OF ACUTE HEPATIC PORPHYRIA, OR 3) A REDUCTION IN THE LEVELS OF URINARY OR PLASMA AMINOLEVULINIC ACID (ALA) OR URINARY OR PLASMA PORPHOBILINOGEN (PBG).

GLEOSTINE(GHP)

MEDICATION(S)
GLEOSTINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of primary or metastatic brain tumors, following appropriate surgical or radiotherapeutic procedures. Diagnosis of Hodgkin lymphoma in patients who have progressive disease following initial chemotherapy, used in combination with other chemotherapy agents.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

GLP(GHP)

MEDICATION(S)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN, OZEMPIC (2 MG/DOSE), RYBELSUS, TRULICITY, VICTOZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Type 2 diabetes mellitus

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

GRALISE(GHP)

MEDICATION(S)
GABAPENTIN (ONCE-DAILY), GRALISE 450 MG TAB, GRALISE 750 MG TAB, GRALISE 900 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF POSTHERPETIC NEURALGIA (PHN).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO USE OF GAPAPENTIN IR AND PREGABALIN IR.

GROWTH HORMONE(GHP)

MEDICATION(S)
NORDITROPIN FLEXPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
GROWTH HORMONE STIMULATION TESTS, IGF-I LEVELS, GROWTH VELOCITY CURVES

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST OR NEPHROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

HAEGARDA(GHP)

MEDICATION(S)
HAEGARDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HEREDITARY ANGIOEDEMA and FOR HAE TYPE I AND TYPE II: THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDMEA WITHOUT URTICARIA SUPPORTED BY DOCUMENTATION OF LOW C4 LEVELS AND LESS THAN 50 PERCENT OF THE LOWER LIMIT OF NORMAL C1 INH ANTIGENIC PROTEIN LEVELS OR FUNCTION LEVELS

AGE RESTRICTION
MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
If being used for prophylaxis: documentation that medication is not being used in combination with another prophylactic human C1 esterase inhibitor (Cinryze), berotralstat (Orladeyo) or lanadelumab (Takhzyro) therapy for hereditary angioedema. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

HALAVEN(GHP)

MEDICATION(S)
ERIBULIN MESYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC BREAST CANCER OR DIAGNOSIS OF UNRESECTABLE OR METASTATIC LIPOSARCOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR BREAST CA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST 2 PRIOR CHEMOTHERAPEUTIC REGIMENS. PRIOR THERAPY SHOULD HAVE INCLUDED AN ANTHRACYCLINE AND A TAXANE IN THE ADJUVANT OR METASTATIC SETTING. FOR LIPOSARCOMA: DOCUMENTATION OF A PREVIOUS TRIAL OF AN ANTHRACYCLINE CONTAINING REGIMEN. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

HETLIOZ(GHP)

MEDICATION(S)
HETLIOZ LQ, TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF NON-24-HOUR SLEEP-WAKE DISORDER (FREE-RUNNING DISORDER) AND DOCUMENTATION THAT THE MEMBER IS TOTALLY BLIND WITH NO PERCEPTION OF LIGHT. DOCUMENTATION OF A DIAGNOSIS OF NIGHTTIME SLEEP DISTURBANCES IN SMITH-MAGENIS SYNDROME (SMS).

AGE RESTRICTION
SLEEP WAKE DISORDER:18 YRS OF AGE OR OLDER. SMS: 3 YRS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION FOR NON-24-HOUR SLEEP WAKE DISORDER WILL REQUIRE DOCUMENTATION OF PROVER ASSESSED INCREASE IN NIGHTTIME SLEEP OR A DECREASE IN DAYTIME SLEEP. REAUTHORIZATION FOR SMS WILL REQUIRE DOCUMENTATION OF PROVIDER ASSESSED INCREASE IN NIGHTTIME SLEEP OR A DECREASE IN NIGHTTIME SLEEP DISTURBANCES.

HUMIRA(GHP)

MEDICATION(S)
HUMIRA (2 PEN) 40 MG/0.8ML PEN KIT, HUMIRA (2 SYRINGE), HUMIRA 10 MG/0.1ML PREF SY KT (ABBVIE), HUMIRA 20 MG/0.2ML PREF SY KT (ABBVIE), HUMIRA 40 MG/0.4ML PREF SY KT (ABBVIE), HUMIRA PEDIATRIC CROHNS START, HUMIRA PEN 40 MG/0.4ML PEN KIT (ABBVIE), HUMIRA PEN 80 MG/0.8ML PEN KIT (ABBVIE), HUMIRA PEN-CD/UC/HS STARTER 80 MG/0.8ML PEN KIT (ABBVIE), HUMIRA PEN-PEDIATRIC UC START 80 MG/0.8ML PEN KIT (ABBVIE), HUMIRA PEN-PSOR/UVEIT STARTER, HUMIRA-CD/UC/HS STARTER, HUMIRA-PS/UV/ADOL HS STARTER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ADULT RA - DX OF RA MADE IN ACCORDANCE WITH THE ACR CRITERIA. JIA - DX OF MODERATE TO SEVERE JIA. PSORIATIC ARTHRITIS - DX OF MODERATE TO SEVERE PSA AND ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS. DIAGNOSIS OF PERIPHERAL PSA. DIAGNOSIS OF AXIAL PSA. PLAQUE PSORIASIS - DX OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. CROHN'S -DOCUMENTATION OF MODERATE OR HIGH RISK PATIENT OR A DX OF CROHNS DISEASE WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE, AZATHIOPRINE, CORTICOSTEROIDS OR METHOTREXATE. ANKYLOSING SPONDYLITIS - DX OF A.S. AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 2 FORMULARY NSAIDS. ULCERATIVE COLITIS - DX OF MODERATE TO SEVERE UC WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE, AZATHIOPRINE, CORTICOSTEROIDS OR AMINOSALICYLATES (SUCH AS BUT NOT LIMITED TO MESALAMINE, OLSALAZINE, OR SULFASALAZINE). FOR HIDRADENITIS SUPPURATIVA (HS)-DX OF MODERATE TO SEVERE HS, DEFINED AS STAGE II OR III ON THE HURLEY STAGING SYSTEM AND DOCUMENTATION OF

AT LEAST 3 ABSCESSES OR INFLAMMATORY NODULES. UVEITIS - DX OF NON-INFECTIOUS ITERMEDIATE, POSTERIOR OR PANUVEITIS.

AGE RESTRICTION

MUST BE AT LEAST 18 YEARS FOR: PSORIASIS, PSA, RA, AND ANKYLOSING SPONDYLITIS. MUST BE AT LEAST 2 YEARS OF AGE FOR PJIA OR UVEITIS. MUST BE AT LEAST 5 YEARS OF AGE FOR UC. MUST BE AT LEAST 6 YEARS OF AGE FOR CROHNS. MUST BE AT LEAST 12 YEARS OF AGE FOR HS.

PRESCRIBER RESTRICTION

RHEUMATOLOGIST, GASTROENTEROLOGIST, DERMATOLOGIST OR OPHTHALMOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE DISEASE MODIFYING ANTI-RHEUMATIC DRUG (DMARD), SUCH AS BUT NOT LIMITED TO METHOTREXATE, LEFLUNOMIDE OR SULFASALAZINE. FOR JIA: THERAPEUTIC FALIURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY NSAID AND ONE OF THE FOLLOWING DMARDS: LEFLUNOMIDE OR METHOTREXATE. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO TWO FORMULARY NSAIDS. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE OR PHOTOTHERAPY. FOR UVEITIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE LOCAL OR SYSTEMIC CORTICOSTEROID AND EITHER ONE IMMUNOSUPPRESSANT OR IF UNDER 18 YEARS OF AGE, METHOTRAXATE. FOR UC: IF REQUEST IS FOR WEEKLY DOSING ONE OF THE FOLLOWING: INADEQUATE DRUG TROUGH LEVELS TO SUPPORT WEEKLY DOSING PER AGA GUIDELINES OR DOCUMENTATION THAT WEEKLY DOSING WAS INITIATED PRIOR TO THE MEMBER TURNING 18 YEARS AND THE MEMBER IS WELL-CONTROLLED ON THIS DOSE OR MEMBER IS LESS THAN 18 YEARS OF AGE AND RECEIVING AN APPROPRIATE DOSE BASED ON BODY WEIGHT. FOR CONTINUED THERAPY MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

HYFTOR(GHP)

MEDICATION(S)
HYFTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of facial angiofibroma associated with tuberous sclerosis.

AGE RESTRICTION
6 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months initial. 6 months reauthorization.

OTHER CRITERIA
Documentation of age appropriate dosing (less than or equal to 600 mg per day for those 6 to 11 years of age OR less than or equal to 800 mg per day for those 12 years of age or older). Reauthorization will require documentation of clinical improvement or lack of progression in symptoms of facial angiofibroma.

IBRANCE(GHP)

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HORMONE RECEPTOR POSITIVE, HER2 NEGATIVE ADVANCED OR METASTATIC BREAST CANCER and ONE OF THE FOLLOWING: PRESCRIBED FOR INITIAL ENDOCRINE BASED THERAPY IN COMBINATION WITH AN AROMATASE INHIBITOR (i.e. LETROZOLE) or AFTER DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY, USED IN COMBINATION WITH FULVESTRANT.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ICLUSIG(GHP)

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CHRONIC PHASE, ACCELERATED PHASE, OR BLAST PHASE CHRONIC MYELOID LEUKEMIA (CML) OR PHILADELPHIA CHROMOSOME POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ALL).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For chronic phase (CP) chronic myeloid leukemia: documentation of resistance or intolerance to at least two prior kinase inhibitors. For accelerated phase or blast phase CML: DOCUMENTATION OF RESISTANCE OR INTOLERANCE TO ONE PRIOR TYROSINE KINASE INHIBITOR THERAPY OR DOCUMENTATION OF CELL MUTATION T3151. For Philadelphia chromosome positive acute lymphoblastic leukemia: Documentation of newly diagnosed Ph+ ALL in which medication will be give in combination with chemotherapy OR either documentation of of resistance or intolerance to one prior tyrosine kinase inhibitor therapy or documentation of cell mutation T3151. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

IDHIFA(GHP)

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of relapsed or refractory acute myeloid leukemia AND documentation of an isocitrate dehydrogenase-2 (IDH2) mutation as detected by and FDA approved test

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression

IGALMI(GHP)

MEDICATION(S)
IGALMI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF SCHIZOPHRENIA OR BIPOLAR I OR II DISORDER. DOCUMENTATION THAT IGALMI WILL BE USED FOR THE ACUTE TREATMENT OF AGITATION. DOCUMENTATION THAT IGALMI WILL BE ADMINISTERED UNDER THE SUPERVISION OF A HEALTHCARE PROVIDER.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
7 DAYS

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THE ACUTE USE OF AN ANTIPSYCHOTIC AND A BENZODIAZEPINE FOR THE MANAGEMENT OF AGITATION.

ILARIS(GHP)

MEDICATION(S)
ILARIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS), INCLUDING FAMILIAL COLD AUTOINFLAMMATORY SYNDROME (FCAS) AND MUCKLE-WELLS SYNDROME (MWS) SUPPORTED BY DOCUMENTATION OF GENETIC TESTING TO IDENTIFY THE CIAS1/NLRP-3 GENE MUTATION. DIAGNOSIS OF SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) AND MEDICAL RECORD DOCUMENTATION OF ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) DIAGNOSED PRIOR TO AGE 16 YEARS, CHARACTERIZED BY GREATER OR EQUAL TO 2 JOINTS WITH ACTIVE ARTHRITIS AND SPIKING, INTERMITTENT FEVER (GREATER THAN 38 DEGREES C) WITHOUT INFECTIOUS CAUSE AND CRP GREATER THAN 30 MG/DL). DIAGNOSIS OF TUMOR NECROSIS FACTOR RECEPTOR ASSOCIATED PERIODIC SYNDROME (TRAPS) SUPPORTED BY DOCUMENTATION OF GENETIC TESTING TO IDENTIFY THE TNFRSF1A GENE MUTATION. DIAGNOSIS OF HYPERIMMUNOGLOBULIN D SYNDROME (HIDS) OR MEVALONATE KINASE DEFICIENCY (MKD) WITH DOCUMENTATION OF ELEVATED IGG D LEVEL OR GENETIC TESTING TO IDENTIFY THE MVK GENE MUTATION. DIAGNOSIS OF FAMILIAL MEDITERRANEAN FEVER (FMF) AS CONFIRMED BY GENETIC TESTING TO IDENTIFY THE MEFV GENE MUTATION. DIAGNOSIS OF ADULT ONSET STILL'S DISEASE DIAGNOSED AFTER AGE 16 YEARS WITH ACTIVE DISEASE CHARACTERIZED BY DISEASE ACTIVITY BASED ON DISEASE ACTIVITY SCORE 28 (DAS28) OF 3.2 OR GREATER AND DOCUMENTATION OF AT LEAST 4 PAINFUL AND 4 SWOLLEN JOINTS AT SCREENING AND BASELINE. DIAGNOSIS OF ACUTE GOUT FLARE.

AGE RESTRICTION
CAPS: 4 YEARS OF AGE OR OLDER. SJIA: 2 YEARS OF AGE OR OLDER. GOUT: 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION

FOR CAPS, TRAPS, HIDS,MKD OR FMF: PRESCRIBED BY AN IMMUNOLOGIST, RHEUMATOLOGIST, DERMATOLOGIST OR ALLERGIST. FOR SJIA, STILLS, OR GOUT: PRESCRIBED BY A RHEUMATOLOGIST.

COVERAGE DURATION

FOR CAPS: 12 WEEKS THEN 1 YEAR. FOR GOUT: 3 MONTHS. FOR ALL OTHER INDICATIONS: 6 MONTHS THEN 1 YEAR.

OTHER CRITERIA

FOR SJIA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ACTEMRA. FOR FMF: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO COLCHICINE. FOR CAPS: FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO KINERET. FOR GOUT: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BOTH OF THE FOLLOWING: (1) 1 FORMULARY NSAID OR COLCHICINE AND (2) 1 FORMULARY CORTICOSTEROID. REAUTHORIZATION WITH REQUIRE CONTINUED IMPROVEMENT IN THE SIGNS AND SYMPTOMS OF THE DISEASE.

IMBRUVICA(GHP)

MEDICATION(S)
IMBRUVICA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LEUKEMIA (SLL) or CLL/SLL WITH 17P DELETION. DIAGNOSIS OF WALDENSTROM MACROGLOBULINEMIA. DIAGNOSIS OF CHRONIC GRAFT VERSUS HOST DISEASE AFTER FAILURE OF ONE OR MORE LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST OR TRANSPLANT SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CHRONIC GRAFT VERSUS HOST DISEASE: DOCUMENTATION THAT MEMBER IS RECEIVING AN APPROPRIATE DOSE BASED ON THE PATIENTS AGE AND BODY SURFACE AREA. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

IMFINZI(GHP)

MEDICATION(S)
IMFINZI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE STAGE III NON-SMALL CELL LUNG CANCER (NSCLC) WITH DOCUMENTATION THAT PATIENT HAS RECEIVED AND HAS NOT PROGRESSED FOLLOWING A MINIMUM OF TWO CYCLES OF CONCURRENT PLATINUM-BASED CHEMOTHERAPY AND RADIATION THERAPY. DIAGNOSIS OF METASTATIC NSCLC AND NO SENSITIZING EPIDERMAL GROWTH FACTOR (EGFR) MUTATION OR ANAPLASTIC LYMPHOMA KINASE (ALK) GENOMIC TUMOR ABERRATIONS AND DOCUMENTATION OF USE IN COMBINATION WITH TREMELIMUMAB-ACTL AND PLATINUM-BASED CHEMOTHERAPY. DIAGNOSIS OF EXTENSIVE-STAGE SMALL CELL LUNG CANCER USED IN COMBINATION WITH ETOPOSIDE AND EITHER CARBOPLATIN OR CISPLATIN. DIAGNOSIS OF UNRESECTABLE HEPATOCELLULAR CARCINOMA (uHCC) AND DOCUMENTATION OF USE IN COMBINATION WITH TREMELIMUMAB-ACTL. DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC BILIARY TRACT CANCER (BTC) AND DOCUMENTATION OF USE IN COMBINATION WITH GEMCITABINE AND CISPLATIN.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
STAGE III NSCLC: 12 MONTHS. ALL OTHER INDICATIONS: 6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA

REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REAUTHORIZATION FOR STAGE III NSCLC BEYOND 1 YEAR WILL REQUIRE DOCUMENTATION OF PEER REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

IMJUDO(GHP)

MEDICATION(S)
IMJUDO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE HEPATOCELLULAR CARCINOMA AND DOCUMENTATION OF USE IN COMBINATION WITH DURVALUMAB. DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER AND NO SENSITIZING EPIDERMAL GROWTH FACTOR (EGFR) MUTATION OR ANAPLASTIC LYMPHOMA KINASE (ALK) GENOMIC TUMOR ABERRATIONS AND DOCUMENTATION OF USE IN COMBINATION WITH DURVALUMAB AND PLATINUM-BASED CHEMOTHERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FOR REQUESTS EXCEEDING THE FDA-APPROVED TREATMENT DURATION OF 16 WEEKS, DOCUMENTATION OF PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

INFLIXIMAB(GHP)

MEDICATION(S)
RENFLEXIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CROHN'S DISEASE- DIAGNOSIS OF MODERATE TO SEVERE CROHN'S OR CROHN'S WITH ACTIVE DRAINING FISTULAS AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA. RA - DIAGNOSIS OF MODERATE TO SEVERE RA MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA AND BEING USED IN CONJUNCTION WITH METHOTREXATE. ANKYLOSING SPONDYLITIS - DIAGNOSIS OF ANKYLOSING SPONDYLITIS. PLAQUE PSORIASIS - DIAGNOSIS OF CHRONIC, SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE PSA AND HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS. ULCERATIVE COLITIS - DIAGNOSIS OF MODERATE TO SEVERE UC

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS OF AGE FOR THE FOLLOWING DIAGNOSES - RA, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, PSORIATIC ARTHRITIS. MUST BE AT LEAST 6 YEARS OF AGE FOR CROHNS DISEASE AND ULCERATIVE COLITIS.

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, DERMATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA. FOR UC: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA OR DOCUMENTATION THAT INFLIXIMAB IS BEING PRESCRIBED TO INDUCE DISEASE REMISSION. FOR PSORIATIC ARTHRITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA. FOR PLAQUE PSORIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA. FOR ANKYLOSING SPONDYLITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INFLIXIMAB-AXXQ (AVSOLA) or INFLECTA. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

INGREZZA(GHP)

MEDICATION(S)
INGREZZA 40 & 80 MG CAP THPK, INGREZZA 40 MG CAP, INGREZZA 60 MG CAP, INGREZZA 80 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of tardive dyskinesia as evidenced by either moderate to severe abnormal body movements (AIMS score 3 or 4) in at least 1 body area or mild abnormal body movements (AIMS score 1 or 2) in 2 or more body areas AND documentation of no other causes of involuntary movements AND documentation of baseline AIMS score prior to initiating therapy AND if the symptoms are related to use of a first-generation antipsychotic, documentation that a switch to a second generation antipsychotic has been attempted and did not resolve symptoms OR provider rationale as to why a switch to a second generation antipsychotic would not be appropriate. DIAGNOSIS OF HUNTINGTON'S DISEASE AND DOCUMENTATION OF SYMPTOMS OF CHOREA AND DOCUMENTATION OF PATIENT'S BASELINE TOTAL MAXIMAL CHOREA SCORE PRIOR TO INITIATING THERAPY AND ONE OF THE FOLLOWING: (1) DOCUMENTATOIN THAT PATIENT WAS EVALUATED AND TREATED BY PSYCHIATRIST IF THERE IS HISTORY OF PRIOR SUICIDE ATTEMPT, BIPOLAR DISORDER, OR MDD OR (2) DOCUMENTATION OF MENTAL HEALTH EVALUATION PERFORMED BY PRESCRIBER.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH PSYCHIATRIST OR NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

FOR HD: DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TETRABENAZINE. Reauthorization FOR TD will require documentation of improvement in condition as evidenced by a reduction from baseline AIMS score. REAUTHORIZATION FOR HD WILL REQUIRE AN IMPROVEMENT IN CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE AS EVIDENCED BY A REDUCTION IN THE TOTAL MAXIMAL CHOREA SCORE FROM BASELINE.

INJECTABLE ANTIPSYCHOTICS(GHP)

MEDICATION(S)
ABILIFY MAINTENA, ARISTADA, INVEGA SUSTENNA, INVEGA TRINZA, RISPERIDONE MICROSPHERES ER, ZYPREXA RELPREVV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR ABILIFY MAINTENA - DIAGNOSIS OF SCHIZOPHRENIA or BIPOLAR I DISORDER AS MONOTHERAPY. FOR ARISTADA, INVEGA TRINZA AND ZYPREXA RELPREVV - DIAGNOSIS OF SCHIZOPHRENIA. FOR INVEGA SUSTENNA - DIAGNOSIS OF SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDERS AS MONOTHERAPY OR AS AN ADJUNCT TO MOOD STABILIZERS OR ANTIDEPRESSANTS. FOR RISPERIDONE ER INJECTION - SCHIZOPHRENIA OR BIPOLAR I DISORDER AS MONOTHERAPY OR AS ADJUNCTIVE THERAPY TO LITHIUM OR VALPROATE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF FAILURE ON OR INTOLERANCE TO ORAL EQUIVALENT OF REQUESTED INJECTABLE THERAPY. FOR INVEGA TRINZA - DOCUMENTATION THAT THE PATIENT HAS BEEN ADEQUATELY TREATED WITH INVEGA SUSTENNA FOR AT LEAST 4 MONTHS.

INLYTA(GHP)

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ADVANCED RENAL CELL CARCINOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For advanced RCC: documentation of failure on one prior systemic therapy OR use as first line treatment in combination with either pembrolizumab or avelumab. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

INQOVI(GHP)

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

INREBIC(GHP)

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of intermediate (INT-2) or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis AND documentation of platelet count greater than or equal to 50 X 10(9)/L AND documentation of splenomegaly (as measured by CT, MRI or ultrasound) AND documentation of a baseline total symptom score measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
Documentation that member is ineligible for allogeneic hematopoietic cell transplantation. Documentation that medication will not be used in combination with another Janus kinase inhibitor (i.e. ruxolitinib). Reauthorization will require documentation of platelet count greater than or equal to 50 x 10(9)/L AND either a reduction of at least 35% in spleen volume from pretreatment baseline OR achievement of a 50% or greater reduction in Total Symptom Score from baseline as measured by the MFSAF.

INSULIN CONCENTRATE(GHP)

MEDICATION(S)
HUMULIN R U-500 KWIKPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of type 1 or type 2 diabetes mellitus

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation that patient requires a total dose of at least 200 units of insulin per day. Documentation that member has been instructed on the appropriate dosing of the medication, including the differences between this and u-100 insulin.

INTUNIV(GHP)

MEDICATION(S)
GUANFACINE HCL ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

AGE RESTRICTION
MUST BE BETWEEN 6 TO 17 YEARS OF AGE.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY STIMULANTS

INVEGA HAFYERA(GHP)

MEDICATION(S)
INVEGA HAFYERA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF FAILURE ON OR INTOLERANCE TO ORAL EQUIVALENT FORM OF MEDICATION. DOCUMENTATION THAT THE PATIENT HAS BEEN ADEQUATELY TREATED WITH INVEGA SUSTENNA FOR AT LEAST 4 MONTHS OR WITH INVEGA TRINZA FOR AT LEAST 3 MONTHS.

IRESSA(GHP)

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER WITH EGFR EXON 19 DELETIONS OR EXON (L858R) SUBSTITUTION MUTATIONS AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ISTODAX(GHP)

MEDICATION(S)
ROMIDEPSIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CUTANEOUS T-CELL LYMPHOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF DISEASE PROGRESSION WHILE ON AT LEAST ONE PRIOR SYSTEMIC THERAPY INCLUDING BUT NOT LIMITED TO CHOP REGIMENS, CHOEP, ICE, IVE, EPOCH, HYPERCVAD.

ITRACONAZOLE(GHP)

MEDICATION(S)
ITRACONAZOLE 100 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
POSITIVE CULTURE SUBSTANTIATING DIAGNOSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR ONYCHOMYCOSIS: FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO TERBINAFINE

IVERMECTIN(GHP)

MEDICATION(S)
IVERMECTIN 3 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
TREATMENT OR PREVENTION OF COVID-19 INFECTION

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF STRONGYLOIDIASIS OF THE INTESTINAL TRACT (NON-DISSEMINATED), ONCHOCERCIASIS, OR USE FOR A MEDICALLY ACCEPTED INDICATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
N/A

IVIG(GHP)

MEDICATION(S)
ASCENIV, BIVIGAM, CUTAQUIG, CUVITRU, FLEBOGAMMA DIF, GAMMAGARD, GAMMAGARD S/D LESS IGA, GAMMAPLEX 10 GM/100ML SOLUTION, GAMMAPLEX 20 GM/200ML SOLUTION, GAMMAPLEX 5 GM/50ML SOLUTION, GAMUNEX-C, HIZENTRA, HYQVIA, PANZYGA, PRIVIGEN, XEMBIFY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
USE OF IVIG FOR THE FOLLOWING INDICATIONS IS CONSIDERED INVESTIGATIONAL AND WILL NOT BE COVERED: ALZHEIMER'S DISEASE, AMYOTROPHIC LATERAL SCLEROSIS, ATOPIC DERMATITIS, AUTISM, CHRONIC FATIGUE SYNDROME, CHRONIC MUCOCUTANEOUS CANDIDIASIS, COMPLEX REGIONAL PAIN SYNDROME, EPILEPSY, INCLUSION BODY MYOSITIS, LYME DISEASE, NEUROMYELITIS OPTICA (DEVIC'S DISEASE), OPTIC NEURITIS, PARAPROTEINEMIC DEMYELINATING NEUROPATHY, POST-POLIO SYNDROME, RECURRENT SPONTANEOUS MISCARRIAGE, RHEUMATIC FEVER, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS, SYSTEMIC LUPUS ERYTHEMATOSUS.

REQUIRED MEDICAL INFORMATION
PRIMARY IMMUNODEFICIENCY: DOCUMENTATION OF IG DEFICIENCY AND AN INABILITY TO AMOUNT AN IMMUNOLOGIC RESPONSE TO INCITING ANTIGENS AND DOCUMENTATION OF SEVERE INFECTIONS DESPITE TX WITH PROPHYLACTIC ANTIBIOTICS. ACUTE ITP: (1) ACTIVE BLEEDING AND PLATELET COUNT LESS THAN 30,000/MM3 OR PRE-OP TX PRIOR TO SURGICAL PROCEDURE OR DOCUMENTED HISTORY OF SIGNIFICANT BLEEDING AND A PLATELET COUNT OF LESS THAN 30,000/MM3 OR A PLATELET COUNT OF LESS THAN 20,000/MM3 AND (2) DOCUMENTATION OF USE WITH A CORTICOSTEROID OR A CONTRAINDICATION OR FAILURE ON CORTICOSTEROID. CHRONIC ITP: (1) DURATION OF IMMUNE THROMBOCYTOPENIA (ITP) GREATER THAN 12 MONTHS AND (2) NO CONCURRENT ILLNESS OR DISEASE EXPLAINING THROMBOCYTOPENIA AND (3) DOCUMENTATION OF PRIOR TREATMENT WITH A LONG COURSE OF HIGH DOSE CORTICOSTEROIDS AND A SPLENECTOMY IF OVER 12 MONTHS HAVE ELAPSED FROM DATE OF INITIAL DIAGNOSIS OR

(4) ACTIVE BLEEDING AND A PLATELET COUNT LESS THAN 30,000/MM3 OR DOCUMENTED HISTORY OF SIGNIFICANT BLEEDING AND A PLATELET COUNT OF LESS THAN 30,000/MM3 OR A PLATELET COUNT OF LESS THAN 20,000/MM3 OR AS A PREOPERATIVE TREATMENT PRIOR TO MAJOR INVASIVE SURGICAL PROCEDURES. CLL: DX OF CLL, AND IGG LEVEL LESS THAN 500 MG/DL, AND HX OF BACTERIAL INFECTION REQUIRING ORAL OR IV ABX TX W/IN LAST 6 MONTHS. CIDP: DX OF CIDP, DOCUMENTED EVIDENCE OF FOCAL OR SYMMETRIC NEUROLOGIC DEFICITS THAT ARE PROGRESSIVE OR RELAPSING OVER 12 WEEKS OR LONGER, AND EMG ABNORMALITIES CONSISTENT WITH CIDP. MMN: SYMPTOMATIC DISEASE FOR A MIN. OF 2 MONTHS WITH FINDINGS OF CONDUCTION BLOCK ON A SINGLE NERVE OR PROBABLE CONDUCTION BLOCK IN 2 OR MORE NERVES OR NORMAL SENSORY NERVE CONDUCTION IN UPPER LIMB SEGMENTS AND NORMAL SENSORY NERVE ACTION POTENTIAL AMPLITUDE. KAWASAKI: MUST BEGIN TX W/IN 10 DAYS OF THE ONSET OF FEVER.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

FOR CIDP AND MULTIFOCAL MOTOR NEUROPATHY: MUST BE PRESCRIBED BY A NEUROLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

CDIP AND MULTIFOCAL MOTOR NEUROPATHY: 12 WEEKS. ALL OTHERS: 6 MONTHS.

OTHER CRITERIA

IVIG MAY BE COVERED UNDER MEDICARE PART B OR MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. CONTINUATION OF COVERAGE WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF A MEAURABLE RESPONSE OR IMPROVMENT IN SIGNS AND SYMPTOMS.

IWILFIN(GHP)

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of use to reduce the risk of relapse in patients with high-risk neuroblastoma (HRNB) AND documentation that the member demonstrated at least a partial response to prior multiagent, multimodaility therapy including anti-GD2 immunotherapy.

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

IXEMPRA(GHP)

MEDICATION(S)
IXEMPRA KIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF USE IN COMBO WITH CAPECITABINE FOR THE TREATMENT OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER WITH RESISTANCE TO AN ANTHRACYCLINE AND A TAXANE OR CANCER THAT IS TAXANE RESISTANT AND FURTHER ANTHRACYCLINE THERAPY IS CONTRAINDICATED OR DOCUMENTATION OF USE AS A MONOTHERAPY WITH TUMORS RESISTANT OR REFRACTORY TO ANTHRACYCLINES, TAXANES AND CAPECITABINE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

JADENU(GHP)

MEDICATION(S)
DEFERASIROX 180 MG PACKET, DEFERASIROX 180 MG TAB, DEFERASIROX 360 MG PACKET, DEFERASIROX 360 MG TAB, DEFERASIROX 90 MG PACKET, DEFERASIROX 90 MG TAB, DEFERASIROX GRANULES

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis) OR diagnosis of chronic iron overload caused by non-transfusion dependent thalassemia

AGE RESTRICTION
for tranfusional hemosiderosis: must be 2 years of age or older. For non-transfusional dependent thalassemia: must be 10 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
For transfusional hemosiderosis: documentation of a serum ferritin level greater than 1000 MCG/L. Continuation of coverage requires documentation of a serum ferritin greater than 500 MCG/L, but decreased from baseline. For non-transfusion dependent thalassemia: documentation of LIC (liver iron concentration) greater than 5 milligrams of iron per gram of dry liver tissue weight (FE/Gdw) AND serum ferritin greater than 300 MCG/L. Continuation of coverage requires documentation of a serum ferritin level greater than 300 MCG/L, but decreased from baseline.

JATENZO(GHP)

MEDICATION(S)
JATENZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR TESTOSTERONE REPLACEMENT THERAPY IN ADULT MALES FOR CONDITIONS ASSOCIATED WITH A DEFICIENCY OR ABSENCE OF ENDOGENOUS TESTOSTERONE: PRIMARY HYPOGONADISM (CONGENITAL OR ACQUIRED) OR HYPOGONADOTROPIC HYPOGONADISM (CONGENITAL OR ACQUIRED).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANDROGEN ALTERNATIVES.

JAYPIRCA(GHP)

MEDICATION(S)
JAYPIRCA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MANTLE CELL LYMPHOMA AND DOCUMENTATION OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, INCLUDING A BTK INHIBITOR. DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL) AND DOCUMENTATION OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, INCLUDING A BTK INHIBITOR AND A BCL-2 INHIBITOR.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

JEMPERLI(GHP)

MEDICATION(S)
JEMPERLI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RECURRENT OR ADVANCED ENDOMETRIAL CANCER WITH DOCUMENTATION OF DISEASE PROGRESSION ON OR FOLLOWING PRIOR TREATMENT WITH A PLATINUM CONTAINING REGIMEN AND DOCUMENTATION OF MISMATCH REPAIR DEFICIENT (DMMR) AS DETERMINED BY AN FDA APPROVED TEST AND DOCUMENTATION THAT MEMBER IS NOT A CANDIDATE FOR CURATIVE SURGERY OR RADIATION. DIAGNOSIS OF RECURRENT OR ADVANCED SOLID TUMORS FOLLOWING AT LEAST ONE PRIOR TREATMENT WITH NO SATISFACTORY ALTERNATIVE TREATMENT OPTIONS AND DOCUMENTATION OF MISMATCH REPAIR DEFICIENT (DMMR) AS DETERMINED BY AN FDA APPROVED TEST.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

JEVTANA(GHP)

MEDICATION(S)
JEVTANA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HORMONE-REFRACTORY METASTATIC PROSTATE CANCER USED IN COMBINATION WITH PREDNISONE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF NEUTROPHIL COUNT GREATER THAN 1500 CELLS/MM(3) AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A DOCETAXEL-BASED REGIMEN. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

JOENJA(GHP)

MEDICATION(S)
JOENJA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACTIVATED PHOPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS) AND DOCUMENTATION OF WEIGHT GREATER THAN OR EQUAL TO 45 KG AND DOCUMENTATION OF MUTATION IN PIK3CD OR PIK3R1 GENE.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CLINICAL IMPROVEMENT OR LACK OF PROGRESSION IN SYMPTOMS OF APDS WHILE ON JOENJA THERAPY.

JUXTAPID(GHP)

MEDICATION(S)
JUXTAPID 10 MG CAP, JUXTAPID 20 MG CAP, JUXTAPID 30 MG CAP, JUXTAPID 5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AND ONE OF THE FOLLOWING (1) GENETIC TESTING TO CONFIRM DIAGNOSIS SHOWING A MUTATION IN THE LOW-DENSITY LIPOPROTEIN (LDL) RECEPTOR (LDLR) GENE, APOLIPOPROTEIN B (APOB) GENE, PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TPE 9 (PCSK9) GENE, OR LDL PROTEIN RECEPTOR ADAPTOR 1 (LDLRAP1) GENE OR (2) DIAGNOSIS MADE BASED ON HISTORY OF AN UNTREATED LOW-DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) GREATER THAN 500 MG/DL WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) IN BOTH PARENTS. DOCUMENTATION OF FAILURE TO ADEQUATELY CONTROL LDL LEVELS WITH MAXIMUM TOLERATED STATIN THERAPY (IF STATIN TOLERANT) DEFINED AS LESS THAN OR EQUAL TO 100 MG/DL IN PATIENTS WITHOUT CVD OR LESS THAN OR EQUAL TO 70 MG/DL IN PATIENTS WITH ESTABLISHED CVD AND DOCUMENTATION OF MEDICATION BEING USED IN ADJUNCT WITH OTHER LOW-DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) LOWERING THERAPIES.

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTION
HEPATOLOGIST, LIDIPOLOGIST, ENDOCRINOLOGIST OR CARDIOLOGIST REGISTERED WITH THE JUXTAPID REMS PROGRAM

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO REPATHA OR PRALUENT. IF THE REQUEST IS FOR USE IN COMBINATION WITH EVKEEZA: DOCUMENTATION OF FAILURE TO ADEQUATELY CONTROL LDL LEVELS WITH A MINIMUM 3-MONTH TRIAL OF EVKEEZA WITHOUT THE CONCOMITANT USE OF JUXTAPID.

JYNARQUE(GHP)

MEDICATION(S)
JYNARQUE 15 MG TAB, JYNARQUE 30 MG TAB, JYNARQUE 45 & 15 MG TAB THPK, JYNARQUE 60 & 30 MG TAB THPK, JYNARQUE 90 & 30 MG TAB THPK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Documentation of End Stage Renal Disease

REQUIRED MEDICAL INFORMATION
Diagnosis of Autosomal Dominant Polycystic Kidney Disease (ADPKD) as confirmed by cysts and family history or genetic testing AND documentation that the member is at high risk for rapidly progressing ADPKD

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
Nephrologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Risk for rapidly progressing ADPKD should be documented with one of the following: Mayo classification class 1C, 1D, or 1E OR Total kidney volume greater than 750 mL OR PROPKD score greater than 6 OR kidney length greater than 16.5 cm as measured by ultrasound (if CT and MRI contraindicated). Reauthorization will require documentation that continued therapy is medically appropriate and no documentation of progression to end-stage renal disease (ESRD)

KADCYLA(GHP)

MEDICATION(S)
KADCYLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HER2-POSITIVE, METASTATIC BREAST CANCER. DIAGNOSIS OF HER2-POSITIVE EARLY BREAST CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
METASTATIC BREAST CA: DOCUMENTATION OF PREVIOUS TREATMENT WITH TRASTUZUMAB (HERCEPTIN) AND A TAXANE (PACLITAXEL OR DOCETAXEL), SEPARATELY OR IN COMBINATION. MUST HAVE EITHER RECEIVED PRIOR THERAPY FOR METASTATIC DISEASE OR DEVELOPED DISEASE RECURRENCE DURING OR WITHIN SIX MONTHS OF COMPLETING ADJUVANT THERAPY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. EARLY BREAST CA: DOCUMENTATION OF NEOADJUVANT TREATMENT WITH TRASTUZUMAB AND A TAXANE AND DOCUMENTATION OF RESIDUAL INVASIVE DISEASE DETECTED IN THE SURGICAL SPECIMEN OF THE BREAST OR AXILLARY NODES AFTER COMPLETION OF NEOADJUVANT THERAPY. REAUTHORIZATION FOR EARLY BREAST CANCER SHOULD NOT

EXCEED THE FDA APPROVED TREATMENT DURATION OF 14 CYCLES OR WILL REQUIRE DOCUMENTATION OF PEER REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS INDICATING THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

KALYDECO(GHP)

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CYSTIC FIBROSIS AND DOCUMENTATION OF ONE MUTATION IN CFTR GENE THAT IS RESPONSIVE TO IVACAFTOR POTENTIATION PER PRODUCT LABELING AS EVIDENCED BY AN FDA CLEARED CF MUTATION TEST, AND DOCUMENTATION THAT THE PATIENT IS NOT HOMOZYGOUS FOR THE F508DEL MUTATION IN THE CFTR GENE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CYSTIC FIBROSIS SPECIALIST

COVERAGE DURATION
4 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OR STABILIZATION IN THE SIGNS AND SYMPTOMS OF CYSTIC FIBROSIS.

KERENDIA(GHP)

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF CHRONIC KIDNEY DISEASE ASSOCIATED WITH TYPE 2 DIABETES.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF SERUM POTASSIUM LESS THAN OR EQUAL TO 5.0 MEQ/L OR LESS THAN OR EQUAL TO 5.5 MEQ/L IF ALREADY ESTABLISHED ON THERAPY. DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO DAPAGLIFLOZIN.

KEVZARA(GHP)

MEDICATION(S)
KEVZARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. DX OF POLYMYALGIA RHEUMATICA (PMR) MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY/EUROPEAN UNION LEAGUE AGAINST RHEUMATISM (ACR/EULAR) CLASSIFICATION CRITERIA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ). FOR PMR: DOCUMENTATION OF ONE OF THE FOLLOWING: (1) THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SYSTEMIC CORTICOSTEROIDS OR (2) DOCUMENTATION THAT MEMBER IS UNABLE TO TOLERATE A CORTICOSTEROID TAPER. FOR CONTINUED THERAPY, MEDICAL RECORD

DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

KEYTRUDA(GHP)

MEDICATION(S)
KEYTRUDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
UNRESEC/METASTAT MELANOMA. COMPLETELY RESECTED STAGE IIB, IIC OR III MM AND MEDICATION USED AS SINGLE AGENT IN ADJ SETTING. METASTAT NSCLC OR METASTAT NONSQUAMOUS NSCLC. RECURRENT/METASTAT/UNRESEC HEAD/NECK SQUAMOUS CELL CA. CLASSICAL HODGKIN LYMPHOMA AND 1 OF: REFRACTORY DISEASE OR AGE GREATER THAN 18 YRS W/RELAPSE FOLLOWING 1 OR MORE PRIOR TX OR AGE LESS THAN 18 YRS W/RELAPSE FOLLOWING 2 OR MORE PRIOR TXS. UNRESEC/METASTAT MSI-H OR dMMR SOLID TUMORS W/PROGRESSION FOLLOWING PRIOR TX OR NO ALTER. TX OPTIONS. FIRST LINE MSI-H or dMMR COLORECTAL CANCER. LOCALLY ADVANCED/METASTAT UROTHELIAL CA AND 1 OF: 1)PROGRESSION AFTER PLATINUM CHEMO OR 2)PROGRESSION W/IN 12 MOS OF (NEO)ADJ PLATINUM CHEMO OR 3) NOT ELIGIBLE FOR PLATINUM CHEMO OR 4) DX OF HIGH RISK, NON-MUSCLE INVASIVE BLADDER CA AND IS UNRESPONSIVE TO TRIAL OF BCG AND INELIGIBLE FOR CYSTECTOMY OR 5) USED IN COMBO W/ PADCEV. LOCALLY ADVANCED UNRESECTABLE/METASTATIC HER-2+ GASTRIC OR GEJ ADENOCA. LOCALLY ADVANCED/METAST SQUAMOUS CELL CA OF THE ESOPHAGUS OR GEJ WHOSE TUMORS EXPRESS PDL1 (CPS GREATER THAN OR EQUAL TO 10), W/PROGRESSION ON 1 OR MORE PRIOR LINES OF SYSTEMIC TX OR IN COMBO W/ PLATINUM AND FLUOROPYRIMIDINE BASED CHEMO FOR DISEASE NOT AMENABLE TO SURGICAL RESECTION OR CHEMORADIATION. RECURRENT/METASTAT CERVICAL CA AND TUMORS EXPRESS PDL1 (CPS GREATER THAN 1) AND 1) DISEASE PROGRESSION AFTER AT LEAST 1 PRIOR TX OR 2) USED IN COMBO W/ CHEMO W/ OR W/O BEVACIZUMAB. FIGO 2014 STAGE III-IVA CERVICAL CA USED IN COMBO W/ CHEMORADIOTHERAPY. REFRACTORY PRIMARY MEDIASTINAL LARGE B-CELL LYMPHOMA OR RELAPSE FOLLOWING 2 OR MORE TXS. HEPATOCELLULAR CA.

METASTAT/RECURRENT MERKEL CELL CA. ADVANCED RENAL CELL CA. ADVANCED ENDOMETRIAL CA. RECURRENT/METASTAT OR LOCALLY ADVANCED CUTANEOUS SQUAMOUS CELL CA NOT CURABLE BY SURGERY/RADIATION. UNRESEC/METASTAT TUMOR MUTATIONAL BURDEN HIGH SOLID TUMORS W/ PROGRESSION FOLLOWING PRIOR TX AND NO ALTER. TX OPTIONS. LOCALLY RECURRENT UNRESEC/METASTAT TRIPLE-NEGATIVE BREAST CA.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION

ADJUVANT TX OF MM/RCC/NSCLC/EARLY STAGE TNBC: 6 MONTHS. ALL OTHERS: 6 MONTHS, 12 MONTHS REAUTH

OTHER CRITERIA

STAGE IB, II, OR IIIA NSCLC: USED AS SINGLE AGENT IN ADJUVANT SETTING AFTER RESECTION AND PLATINUM BASED CHEMOTX. BREAST CA:(1)DX THAT TUMORS EXPRESS PD-L1 (CPS MORE THAN OR EQUAL TO 10) AS DETERMINED BY AN FDA APPROVED TEST AND DOC. OF USE IN COMBO W/ CHEMOTX, OR 2)HIGH-RISK EARLY STAGE TNBC IN COMBO W/ CHEMOTX AS NEOADJUVANT TX AND THEN CONTINUED AS SINGLE AGENT ADJUVANT TX AFTER SURGERY. TMB-H DEFINED AS MORE THAN OR EQUAL TO 10 MUTATIONS/MEGABASE DETERMINED BY AN FDA APPROVED TEST. GASTRIC CA:USED AS 1ST LINE TX IN COMBO W/TRASTUZUMAB, FLUOROPYRIMIDINE AND PLATINUM CONTAINING CHEMOTX. HEAD/NECK SQUAMOUS CELL CARCINOMA: EITHER 1) USED AS SINGLE AGENT FOR DX PROGRESSION ON/AFTER PLATINUM TX, 2) USED AS SINGLE AGENT FOR 1ST LINE TX AND TUMORS EXPRESS PD-L1 (CPS) AT LEAST 1%, 3) USE AS 1ST LINE TX IN COMBO W/ PLATINUM CHEMOTX AND FLUOROURACIL. METASTATIC NSCLC: 1)AS 1ST LINE, MONOTHERAPY FOR STAGE III, METASTATIC DISEASE, OR WHEN NOT ELIGIBLE FOR SURGICAL RESECTION OR CHEMORADIATION AND THAT TUMORS EXPRESS PD-L1 (TPS) AT LEAST 1% AND THAT TUMORS DO NOT HAVE EGFR OR ALK GENOMIC ABERRATIONS OR 2)MONOTHERAPY FOR TPS MORE THAN 1% W/DISEASE PROGRESSION ON/AFTER PLATINUM BASED TX AND IF EGFR OR ALK ABERRATIONS ARE PRESENT, DOC. OF DISEASE PROGRESSION ON ONE FDA APPROVED TX FOR THESE ABERRATIONS OR 3) IN COMBO W/ CARBO/(NAB)PACLITAXEL AS 1ST LINE TX. NONSQUAMOUS NSCLC: USED IN COMBO W/ PEMETREXED AND EITHER CARBO/CISPLATIN AND DOC. THAT TUMORS DO NOT HAVE EGFR OR ALK TUMOR

ABERRATIONS. METASTATIC MELANOMA: DOC. THAT KEYTRUDA IS NOT BEING USED IN COMBO W/ ANY OTHER AGENTS AND IF BEING USED FOR THE ADJUVANT TX OF MM: EVIDENCE OF PRIOR LYMPH NODE INVOLVEMENT WHICH HAS BEEN COMPLETELY RESECTED. HCC: DOC. OF THERAPEUTIC FAILURE OR INTOLERANCE TO SORAFENIB. ADVANCED RCC: DOC. OF USE IN COMBO W/ AXITINIB OR LENVATINIB AND OF BEING USE FOR 1ST LINE TX OF ADVANCED DISEASE. ADJUVANT TREATMENT OF RCC: DOC. OF INTERMEDIATE-HIGH OR HIGH RISK OF RECURRENCE FOLLOWING NEPHRECTOMY/RESECTION OF METASTATIC LESIONS AND BEING USED AS SINGLE AGENT IN ADJUVANT SETTING. ENDOMETRIAL CARCINOMA: 1)DISEASE PROGRESSION FOLLOWING AT LEAST 1 PRIOR SYSTEMIC TX AND 2)NOT A CANDIDATE FOR CURATIVE SURGERY OR RADIATIONAND ONE OF THE FOLLOWING 1)TUMORS ARE NOT MSI-H OR MISMATCH REPAIR DEFICIENT (DMMR) AND 4)WILL BE USED IN COMBO W/ LENVATINIB OR 2) USE AS A SINGLE AGENT FOR TUMORS THAT ARE MSI-H OR MISMATCH REPAIR DEFICIENT (DMMR). SUBSEQUENT APPROVALS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. USE BEYOND 12 TOTAL MOS FOR THE ADJUVANT TREATMENT OF MM/RCC/ADJ NSCLC OR BEYOND 24 WKS NEOADJ OR 27 WKS FOR ADJUV EARLY STAGE TNBC WILL REQUIRE DOCUMENTATION OF CLINICAL TRIALS TO INDICATE THAT THE HEALTHCARE OUTCOME WILL BE IMPROVED BEYOND THE FDA APPROVED TREATMENT DURATION.

KIMMTRAK(GHP)

MEDICATION(S)
KIMMTRAK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF UNRESECTABLE OR METASTATIC UVEAL MELANOMA AND DOCUMENTATION OF HLA-A*02:01–POSITIVE DISEASE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT KIMMTRAK IS NOT BEING USED IN COMBINATION WITH ANY OTHER AGENTS FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC UVEAL MELANOMA. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

KINERET(GHP)

MEDICATION(S)
KINERET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID). DX OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS), INCLUDING FAMILIAL COLD AUTOINFLAMMATORY SYNDROME (FCAS), AND MUCKLE-WELLS SYNDROME (MWS) SUPPORTED BY DOCUMENTATION OF GENETIC TESTING TO IDENTIFY THE CIAS1/NLRP-3 GENE MUTATION. DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS. DIAGNOSIS OF DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA) SUPPORTED BY DOCUMENTATION OF A HOMOZYGOUS OR COMPOUND HETEROZYGOUS MUTATION INVOLVING IL 1 RN (INTERLUEKIN 1 RECEPTOR ANTAGONIST GENE).

AGE RESTRICTION
FOR RA - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
FOR NOMID OR CAPS: PRESCRIBED BY IMMUNOLOGIST, RHEUMATOLOGIST, PEDIATRICIAN OR ALLERGIST. FOR RHEUMATOID ARTHRITIS: PRESCRIBED BY RHEUMATOLOGIST. FOR DIRA: RHEUMATOLOGIST, GENETICIST, DERMATOLOGIST OR A PHYSICIAN SPECIALIZING IN THE TREATMENT OF AUTOINFLAMMATORY DISORDERS.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RHEUMATOID ARTHRITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ). FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

KISQALI(GHP)

MEDICATION(S)
KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE), KISQALI FEMARA(200 MG DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HORMONE RECEPTOR POSITIVE, HER2 NEGATIVE METASTATIC BREAST CANCER. FOR FIRST LINE INITIAL ENDOCRINE THERAPY, ONE OF THE FOLLOWING FOR KISQALI: 1) DOCUMENTATION OF USE IN POSTMENOPAUSAL FEMALES IN COMBINATION WITH EITHER AN AROMATASE INHIBITOR OR FULVESTRANT 2)FOR PRE/PERIMENOPAUSAL FEMALES IN COMBINATION WITH A LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONIST AND AN AROMATASE INHITOR 3) DOCUMENTATION OF USE IN MALES WITH A LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONIST AND EITHER AN AROMATASE INHITOR OR FULVESTRANT. FOR FIRST LINE INITIAL ENDOCRINE THERAPY WITH KISQALI FEMARA CO-PACK: DOCUMENTATION OF USE IN MALES OR PRE/PERIMENOPAUSAL FEMALES IN COMBINATION WITH A LHRH AGONIST OR IN POSTMENOPAUSAL FEMALES. FOR DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY, FOR KISQALI: DOCUMENTATION OF USE IN COMBINATION WITH FULVESTRANT IN POSTMENOPAUSAL FEMALES OR IN MALES UTILIZING AN LHRH AGONIST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

KORLYM(GHP)

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PREGNANCY

REQUIRED MEDICAL INFORMATION
DX OF ENDOGENOUS CUSHING'S SYNDROME AND DOCUMENTATION OF FAILED SURGICAL TREATMENT FOR CUSHING'S SYNDROME OR THAT PATIENT IS NOT A CANDIDATE FOR SURGERY. DOCUMENTATION OF A NEGATIVE PREGNANCY TEST WITHIN 14 DAYS OF INITIATING THERAPY IN WOMEN OF REPRODUCTIVE POTENTIAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

KOSELUGO(GHP)

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of Neurofibromatosis type 1 as defined by a positive NF1 mutation OR documentation of two of the following: 1) Six or more café-au-lait macules (more than 5 mm diameter in prepubertal individuals and more than 15 mm in post-pubertal individuals), 2) Freckling in axillary or inguinal regions, 3) two or more neurofibromas of any type or one plexiform neurofibroma, 4) optic glioma (tumor of nerve to eye), 5) two or more Lisch nodules (iris hamartomas), 6) a distinctive osseous lesion (sphenoid dysplasia or tibial pseudarthrosis), or 7) a first degree relative with NF1. Documentation of symptomatic, inoperable plexiform neurofibromas.

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH AN ONCOLOGIST, NEUROLOGIST OR GENETICIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

KRAZATI(GHP)

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER AND DOCUMENTATION OF A KRAS-G12C MUTATION, AS DETERMINED BY AN FDA APPROVED TEST AND DOCUMENTATION OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

KRYSTEXXA(GHP)

MEDICATION(S)
KRYSTEXXA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC, SYMPTOMATIC GOUT. DOCUMENTATION OF USE IN COMBINATION WITH ORAL METHOTREXATE OR INTOLERANCE TO OR CONTRAINDICATION TO METHOTREXATE. DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY XANTHINE OXIDASE INHIBITORS AT THE MAXIMUM MEDICALLY APPROPRIATE DOSE.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT HIGH-RISK PATIENTS (E.G., PATIENTS OF AFRICAN, MEDITERRANEAN AND SOUTHERN ASIAN ANCESTRY) HAVE BEEN SCREENED FOR G6PD DEFICIENCY. DOCUMENTATION THAT PRESCRIBED DOSE IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE. REAUTHORIZATION WILL REQUIRE CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND ONGOING URIC ACID LEVEL MONITORING PRIOR TO EACH INFUSION. THE TWO MOST RECENT URIC ACID LEVELS (FROM

WITHIN THE PAST 8 WEEKS) MUST BE SUBMITTED. IN INDIVIDUALS WHOSE URIC ACID LEVEL IS ABOVE 6 MG/DL FOR TWO CONSECUTIVE LAB DRAWS, THERAPY SHOULD BE DISCONTINUED AND REAUTHORIZATION WILL NOT BE APPROVED.

KUVAN(GHP)

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BASELINE BLOOD PHE LEVEL LESS THAN 360 UMOL/L.

REQUIRED MEDICAL INFORMATION
Diagnosis of hyperphenylalaninemia. Documentation of blood PHE levels

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST

COVERAGE DURATION
INITIALLY 2 MONTHS THEN EVERY 12 MONTHS IF PATIENT IS A RESPONDER

OTHER CRITERIA
INITIAL REAUTHORIZATION WILL REQUIRE A REDUCTION IN BLOOD PHE LEVELS FROM BASELINE or DOCUMENTATION OF AN INCREASE IN PHE TOLERANCE (such as addition of Phe in diet with stable Phe level). YEARLY REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF SUSTAINED REDUCTION IN BLOOD PHE LEVELS or DOCUMENTATION OF IMPROVEMENT IN NEUROPSYCHIATRIC SYMPTOMS or AN INCREASE IN PHE TOLERANCE.

KYPROLIS(GHP)

MEDICATION(S)
KYPROLIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY. DOCUMENTATION THAT MEDICATION WILL BE USED 1)AS MONOTHERAPY OR 2)IN COMBINATION WITH DEXAMETHASONE OR 3)IN COMBINATION WITH DEXAMETHASONE AND LENALIDOMIDE OR 4)IN COMBINATION WITH DARATUMUMAB AND DEXAMETHASONE OR 5)IN COMBINATION WITH DARATUMUMAB AND HYALURONIDASE-FIHJ AND DEXAMETHASONE OR 6)IN COMBINATION WITH ISATUXIMAB AND DEXAMETHASONE. REAUTHORIZATION WILL REQUIRED DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

LAMZEDE(GHP)

MEDICATION(S)
LAMZEDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ALPHA-MANNOSIDOSIS SUPPORTED BY ONE OF THE FOLLOWING: (1) DOCUMENTATION OF ENZYME ASSAY DEMONSTRATING ALPHA-MANNOSIDASE ACTIVITY LESS THAN 10% OF NORMAL ACTIVITY (LESS THAN 0.54 NMOL/MIN/MG) OR (2) DOCUMENTATION OF MOLECULAR GENETIC TESTING THAT REVEALS PATHOGENIC VARIANTS IN THE MAN2B1 GENE. DOCUMENTATION THAT MEMBER IS BEING TREATED FOR NON-CENTRAL NERVOUS SYSTEM MANIFESTATIONS OF ALPHA-MANNOSIDOSIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR BIOCHEMICAL GENETICIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF A PRESCRIBED DOSE AND ADMINISTRATION THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION (I.E., IMPROVEMENT OR STABILIZATION IN MOTOR FUNCTION, IMPROVEMENT IN FORCED VITAL CAPACITY PERCENTAGE, REDUCTION IN FREQUENCY OF

INFECTIONS, ETC.).

LAZANDA(GHP)

MEDICATION(S)
LAZANDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CANCER AND OF USE TO MANAGE BREAKTHROUGH CANCER PAIN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF CONCOMITANT MORPHINE 60 MG/DAY OR MORE, TRANSDERMAL FENTANYL 25 MCG/H, OXYCODONE 30 MG/DAY, ORAL HYDROMORPHONE 8 MG/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR 1 WEEK OR LONGER AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO GENERIC FENTANYL LOZENGES.

LENVIMA(GHP)

MEDICATION(S)
LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. Diagnosis of use in combination with Afinitor (everolimus) for surgically unresectable advanced or metastatic renal cell carcinoma following a therapeutic failure on or intolerance to one prior anti-angiogenic therapy OR documentation of use in combination with pembrolizumab for first line treatment of advanced renal cell carcinoma. Diagnosis of unresectable hepatocellular carcinoma (HCC) in those who have not received prior therapy AND documentation of Child-Pugh Class A liver disease. Diagnosis of advanced endometrial carcinoma with disease progression following at least one prior systemic therapy in patients not candidates for curative surgery or radiation AND documentation that tumors are NOT microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND documentation of use in combination with pembrolizumab.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

LEQVIO(GHP)

MEDICATION(S)
LEQVIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD), INCLUDING ACUTE CORONARY SYNDROMES (A HISTORY OF MYOCARDIAL INFARCTION OR UNSTABLE ANGINA), CORONARY OR OTHER ARTERIAL REVASCULARIZATION, STROKE, TRANSIENT ISCHEMIC ATTACK, OR PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN OR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA. DOCUMENTATION OF A BASELINE LDL DRAWN WITHIN 3 MONTHS OF THE START OF THERAPY SHOWING AN LDL GREATER THAN 100 IF USING FOR PRIMARY PREVENTION OR AN LDL GREATER THAN 70 IF USING FOR SECONDARY PREVENTION. DOCUMENTATION THAT MEDICATION IS NOT BEING USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR. FOR STATIN TOLERANT PATIENTS, DOCUMENTATION OF AN INABILITY TO ACHIEVE AND MAINTAIN LDL GOAL WITH ONE OF THE FOLLOWING (1) MAXIMUM TOLERATED DOSE OF A HIGH INTENSITY STATIN (ATORVASTATIN 40 MG OR HIGHER OR ROSUVASTATIN 20 MG OR HIGHER) OR (2) A MAXIMALLY TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT HAS HAD A PREVIOUS TRIAL OF EITHER ATORVASTATIN OR ROSUVASTATIN, WITH PRESCRIBERS DOCUMENTATION REGARDING LENGTH OF PREVIOUS TRIALS OF STATINS. PATIENT MUST INTEND TO CONTINUE ON MAXIMAL STATIN THERAPY ONCE LEQVIO IS STARTED. FOR STATIN INTOLERANT PATIENTS, DOCUMENTATION OF REASON FOR STATIN INTOLERANCE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION

CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO REPATHA OR PRALUENT. FOR HEFH DOCUMENTATION OF EITHER GENETIC TESTING TO CONFIRM MUTATION IN THE LDL RECEPTOR, PCSK9, OR APOB GENE OR MEDICAL RECORD DOCUMENTATION OF DEFINITE HEFH (SCORE GREATER THAN 8) ON THE DUTCH LIPID CLINIC NETWORK DIAGNOSTIC CRITERIA. THERAPEUTIC FAILURE IS DEFINED AS AN INABILITY TO REACH TARGET LDL GOALS (LESS THAN 100 MG/DL FOR PATIENTS WITH HEFH IN PRIMARY PREVENTION OR LESS THAN 70 MG/DL FOR ASCVD OR FOR PATIENTS WITH HEFH USING LEQVIO AS SECONDARY PREVENTION) DESPITE AT LEAST A 3 MONTH TRIAL. INTOLERANCE TO STATINS IS DEFINED AS INCREASED LFTS, INTOLERABLE MYALGIA (MUSCLE SYMPTOMS WITHOUT CREATININE KINASE (CK) ELEVATIONS) OR MYOPATHY (MUSCLE SYMPTOMS WITH CK ELEVATIONS), OR MYOSITIS (ELEVATIONS IN CK WITHOUT MUSCLE SYMPTOMS), WHICH PERSIST AFTER TWO RETRIALS WITH A DIFFERENT DOSE OR DIFFERENT DOSING STRATEGY (EVERY OTHER DAY) OF ALTERNATIVE MODERATE- OR HIGH-INTENSITY STATIN. CONTRAINDICATIONS TO STATINS ARE DEFINED AS ACTIVE LIVER DISEASE, PREVIOUS HISTORY OF RHABDOMYOLYSIS, OR HYPERSENSITIVITY. RENEWAL CRITERIA: DOCUMENTATION OF AN UP TO DATE LDL CHOLESTEROL LEVEL SINCE THE PREVIOUS REVIEW SHOWING A CLINICALLY SIGNIFICANT RESPONSE TO TREATMENT AND DOCUMENTATION OF NO SIGNIFICANT ADVERSE EVENTS RELATED TO THERAPY AND DOCUMENTATION OF STILL TAKING STATIN (IF STATIN TOLERANT) AND DOCUMENTATION THAT LEQVIO CONTINUES TO NOT BE USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR.

LETAIRIS(GHP)

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION. DOCUMENTATION OF ONE OF THE FOLLOWING: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL or DOCUMENTATION OF USE AS FIRST LINE THERAPY IN COMBINATION WITH ADCIRCA IN PATIENTS WITH WHO GROUP 1 PAH

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

LEUKINE(GHP)

MEDICATION(S)
LEUKINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For acceleration of myeloid recovery in patients undergoing allogeneic bone marrow transplantation from HLA-matched related donors. For treatment of delayed or failed neutrophil recovery in patients who have undergone allogeneic or autologous bone marrow transplantation. For mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis in patients undergoing autologous hematopoietic stem cell transplantation. In patients with AML receiving induction or consolidation therapy. Hematopoietic syndrome of acute radiation syndrome (H-ARS) with documentation of an acute exposure to myelosuppressive doses of radiation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A

LIBTAYO(GHP)

MEDICATION(S)
LIBTAYO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC CUTANEOUS SQUAMOUS CELL CARCINOMA (CSCC) OR LOCALLY ADVANCED CSCC AND DOCUMENATION THAT THE PATIENT IS NOT A CANDIDATE FOR CURATIVE SURGERY OR CURATIVE RADIATION. DOCUMENTATION OF LOCALLY ADVANCED BASAL CELL CARCINOMA (LABCC) OR METASTATIC BCC (MBCC) AND DOCUMENTATION OF PREVIOUS TREATMENT WITH A HEDGEHOG PATHWAY INHIBITOR OR DOCUMENTATION THAT A HEDGEHOG PATHWAY INHIBITOR IS INAPPROPRIATE. DOCUMENTATION OF NON-SMALL CELL LUNG CANCER (NSCLC) AND 1) DOCUMENTATION OF ONE OF THE FOLLOWING: METASTATIC DISEASE OR LOCALLY ADVANCED DISEASE AND THE PATIENT IS NOT A CANDIDATE FOR SURGICAL RESECTION OR DEFINITIVE CHEMORADIATION AND 2) DOCUMENTATION OF NO EGFR, ALK OR ROS1 GENOMIC TUMOR ABERRATIONS AND 4) DOCUMENTATION OF THAT MEDICATION IS BEING USED AS FIRST LINE TREATMENT AND 5) DOCUMENTATION OF ONE OF THE FOLLOWING: THAT MEDICATION IS BEING USED AS A SINGLE AGENT AND DOCUMENTATION OF HIGH PD-L1 EXPRESSION (TUMOR PROPORTION SCORE (TPS) OF 50% OR GREATER AS DETERMINED BY AN FDA APPROVED TEST OR MEDICATION IS BEING USED IN COMBINATION WITH PLATINUM-BASED CHEMOTHERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

LIDODERM(GHP)

MEDICATION(S)
LIDOCAINE 5 % PATCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF POST-HERPETIC NEURALGIA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

LIQREV(GHP)

MEDICATION(S)
LIQREV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FUNCTIONAL CLASS 2, 3, OR 4 PULMONARY ARTERIAL HYPERTENSION WITHOUT CONCOMITANT USE OF ORGANIC NITRATES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

LIVMARLI(GHP)

MEDICATION(S)
LIVMARLI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF ALAGILLE SYNDROME (ALGS).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEPATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT THE MEMBER IS RECEIVING AN APPROPRIATE DOSE BASED ON THE PATIENT WEIGHT. DOCUMENTATION OF THE PRESENCE OF MODERATE TO SEVERE PRURITUS AND DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CHOLESTYRAMINE, RIFAMPIN, OR NALTREXONE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT IN PRURITUS FROM BASELINE AND DOCUMENTATION THAT THE MEMBER IS RECEIVING AN APPROPRIATE DOSE BASED ON THE PATIENT WEIGHT.

LIVTENCITY(GHP)

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF POST-TRANSPLANT CYTOMEGALOVIRUS (CMV) INFECTION AND DOCUMENTATION THAT INFECTION IS REFRACTORY TO PREVIOUS TREATMENT WITH GANCICLOVIR, VALGANCICLOVIR, CIDOFOVIR OR FOSCARNET.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST, TRANSPLANT SURGEON OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
8 WEEKS

OTHER CRITERIA
DOCUMENTATION THAT PATIENT HAS RECEIVED A HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) OR SOLID ORGAN TRANSPLANT. DOCUMENTATION OF MEMBER WEIGHT OF 35 KG OR MORE. DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH ANOTHER CMV ANTIVIRAL. IF THE REQUEST IS ABOVE 400 MG TWICE DAILY DOSING, DOCUMENTATION OF ONE OF THE FOLLOWING: (1) FOR REQUESTS OF 800 MG TWICE DAILY DOSING: DOCUMENTATION THAT THE MEMBER IS CONCURRENTLY RECEIVING CARBAMAZEPINE OR (2) FOR REQUESTS OF 1200 MG TWICE DAILY DOSING: DOCUMENTATION THAT THE MEMBER IS CONCURRENTLY RECEIVING PHENYTOIN OR

PHENOBARBITAL.

LODOCO(GHP)

MEDICATION(S)
LODOCO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation that medication is being prescribed to reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death AND Documentation of either (1) patient has established atherosclerotic disease OR (2) has two or more risk factors for cardiovascular disease.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation that the member is currently receiving standard of care therapy for chronic coronary disease (i.e. antiplatelets, anticoagulants, lipid-lowering agents, beta-blockers, renin-anitogensin inhibitors) unless contraindicated or not tolerated. Documentation that member has a creatinine clearance of 15 ml/min or greater. Clinical ASCVD includes but is not limited to: acute coronary syndromes, history of myocardial infarction (MI), angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA) or peripheral arterial disease (PAD). Risk factors for cardiovascular disease includes, but is not limited to: family history of premature ASCVD, primary hypercholesterolemia, metabolic syndrome, chronic kidney disease (CKD), current smoker, congestive heart failure, or coronary artery calcium (CAC) score greater than 400.

LOKELMA(GHP)

MEDICATION(S)
LOKELMA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of mild to moderate hyperkalemia

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION THAT ATTEMPT HAS BEEN MADE TO IDENTIFY AND CORRECT THE UNDERLYING CAUSE OF THE HYPERKALEMIA OR RATIONALE AS TO WHY THE UNDERLYING CAUSE CANNOT BE CORRECTED.

LONSURF(GHP)

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of metastatic colorectal cancer AND documentation of previous treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type,an anti-EGFR therapy. Diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma AND documentation of previous treatment with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum agent, either a taxane or irinotecan and if appropriate, HER2/neu-targeted therapy.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

LOQTORZI(GHP)

MEDICATION(S)
LOQTORZI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF METASTATIC OR RECURRENT LOCALLY ADVANCED NASOPHARYNGEAL CARCINOMA (NPC) AND DOCUMENTATION THAT MEDICATION IS BEING GIVEN AS FIRST-LINE TREATMENT IN COMBO W/ CISPLATIN AND GEMCITABINE. DIAGNOSIS OF RECURRENT UNRESECTABLE OR METASTATIC NPC WITH DISEASE PROGRESSION ON OR AFTER A PLATINUM-CONTAINING CHEMOTHERAPY AND DOCUMENTATION THAT MEDICATION IS BEING USED AS A SINGLE AGENT.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

LORBRENA(GHP)

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of ALK-positive metastatic non-small cell lung cancer (NSCLC)

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorization will require documentation of continued disease improvement or lack of disease progression

LUCEMYRA(GHP)

MEDICATION(S)
LUCEMYRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of use to mitigate opioid withdrawal symptoms in patients abruptly discontinuing opioids

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to clonidine.

LUMAKRAS(GHP)

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AND DOCUMENTATION OF A KRAS G12C MUTATION AS DETECTED BY AN FDA APPROVED TEST AND DOCUMENTATION OF TREATEMENT WITH A LEAST ONE PRIOR SYSTEMIC THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

LUMIZYME(GHP)

MEDICATION(S)
LUMIZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF LATE-ONSET (NON-INFANTILE) POMPE DISEASE OR A DIAGNOSIS OF INFANTILE-ONSET POMPE DISEASE SUPPORTED BY GAA ASSAY PERFORMED ON DRIED BLOOD SPOTS, SKIN FIBROBLASTS OR MUSCLE BIOPSY AND BASELINE PULMONARY FUNCTION TESTING (PFT) AND MUSCLE STRENGTH EVALUATION (I.E., PERCENT-PREDICTED FORCED VITAL CAPACITY (%FVC), 6-MINUTE WALK TEST (6MWT), GSGC (GAIT STAIRS, GOWER, CHAIR)) AND FOR LATE-ONSET POMPE DISEASE ONLY: GENETIC TESTING TO IDENTIFY THE SPECIFIC MUTATION TO CONFIRM THE DIAGNOSIS OF LATE-ONSET POMPE DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR BIOCHEMICAL GENETICIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT THE MEMBER IS RECEIVING AN APPROPRIATE DOSE BASED ON WEIGHT AND DOCUMENTATION THAT LUMIZYME WILL NOT BE USED IN COMBINATION WITH OTHER ENZYME REPLACEMENT THERAPY (E.G. NEXVIAZYME). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OR STABILIZATION IN PULMONARY

FUNCTION TESTING AND/OR MUSCLE STRENGTH EVALUATION AND DOCUMENTATION OF RECEIVING AN APPROPRIATE DOSE BASED ON PATIENTS WEIGHT AND DOCUMENTATION THAT MEDICATION IS NOT BEING USED IN COMBINATION WITH OTHER ENZYME REPLACEMENT THERAPY (I.E. NEXVIAZYME).

LUMOXITI(GHP)

MEDICATION(S)
LUMOXITI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF RELAPSED OR REFRACTORY HAIRY-CELL LEUKEMIA AND DOCUMENTATION OF TRIAL OF AT LEAST 2 PRIOR SYSTEMIC THERAPIES, ONE OF WHICH MUST BE A PURINE NUCLEOSIDE ANALOG.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REUTHORIZATION WILL REQUIRE DOCUMENTATION OF MEDICAL OR SCIENTIFIC LITERATURE TO SUPPORT THE USE OF THIS AGENT BEYOND THE FDA APPROVED TREATMENT DURATION

LUNSUMIO(GHP)

MEDICATION(S)
LUNSUMIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA AND DOCUMENTATION OF PRIOR TREATMENT WITH TWO OR MORE LINES OF THERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTH INITIAL, 12 MONTH CONTINUATION

OTHER CRITERIA
AUTHORIZATION OF LUNSUMIO FOR THE TX OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA SHOULD NOT EXCEED THE FDA-APPROVED TREATMENT DURATION OF 8 TOTAL CYCLES FOR PATIENTS WHO ARE IN COMPLETE REMISSION FOLLOWING 8 CYCLES OF LUNSUMIO TREATMENT. AUTHORIZATION OF LUNSUMIO FOR THE TX OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA SHOULD NOT EXCEED THE FDA-APPROVED TREATMENT DURATION OF 17 TOTAL CYCLES FOR PATIENTS WHO ARE IN PARTIAL REMISSION OR STABLE DISEASE FOLLOWING 8 CYCLES OF LUNSUMIO TREATMENT. FOR REQUESTS EXCEEDING THE FDA-APPROVED TREATMENT DURATION, DOCUMENTATION OF THE FOLLOWING IS REQUIRED: PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE

IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

LUPKYNIS(GHP)

MEDICATION(S)
LUPKYNIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACTIVE LUPUS NEPHRITIS, CLASS III, IV, V ALONE OR IN COMBINATION, CONFIRMED BY A KIDNEY BIOPSY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR NEPHROLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION WILL BE PRESCRIBED IN COMBINATION WITH A BACKGROUND IMMUNOSUPPRESSIVE THERAPY REGIMEN (E.G. MYCOPHENOLATE MOFETIL (MMF) AND CORTICOSTEROIDS) AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BENLYSTA. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF A POSITIVE CLINICAL RESPONSE (E.G. IMPROVEMENT/STABILIZATION IN UPCR, EGFR, RENAL RELATED EVENTS) AND DOCUMENTATION THAT MEDICATION WILL BE PRESCRIBED IN COMBINATION WITH A BACKGROUND IMMUNOSUPPRESSIVE THERAPY REGIMEN (E.G. MYCOPHENOLATE MOFETIL (MMF) AND CORTICOSTEROIDS).

LYBALVI(GHP)

MEDICATION(S)
LYBALVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR ONE OF THE FOLLOWING: 1) SCHIZOPHRENIA OR 2) ACUTE TREATMENT OF MANIC OR MIXED EPISODES ASSOCIATED WITH BIPOLAR I DISORDER OR 3) MAINTENANCE TREATMENT OF BIPOLAR I DISORDER.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO OLANZAPINE AND ONE OTHER FORMULARY ATYPICAL ANTIPSYCHOTICS (I.E., RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ARIPIPRAZOLE)

LYNPARZA TABLETS(GHP)

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)MONOTHERAPY IN THE MAINTENANCE TX OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA MUTATED (gBRCAm OR sBRCAm) ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER WHO ARE IN A COMPLETE OR PARTIAL RESPONSE TO 1ST LINE PLATINUM BASED TX 2)IN COMBO W/ BEVACIZUMAB FOR 1ST LINE MAINTENANCE TX OF ADVANCED EPITHELIAL, OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN A COMPLETE OR PARTIAL RESPONSE TO 1ST LINE PLATINUM BASED TX AND WHOSE CANCER IS ASSOC. WITH HOMOLOGOUS RECOMBINATION DEFICIENCY (HRD)-POSITIVE STATUS DEFINED BY EITHER A DELETERIOUS OR SUSPECTED DELETERIOUS BRCA MUTATION AND/OR GENOMIC INSTABILITY 3)AS MONOTHERAPY IN THE MAINTENANCE TX OF RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN A COMPLETE OR PARTIAL RESPONSE TO PLATINUM BASED TX 4)DX OF DELETERIOUS/SUSPECTED DELETERIOUS GBRCAM, HER2-NEGATIVE METASTATIC BREAST CA AND DOC. OF BEING PREVIOUSLY TREATED WITH CHEMOTX IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING AND IF HORMONE RECEPTOR (HR)-POSITIVE DOC. THAT PRIOR TX INCLUDED ENDOCRINE THERAPY OR DOC. THAT SUCH THERAPY WOULD BE INAPPROPRIATE. 5)DX OF DELETERIOUS/SUSPECTED DELETERIOUS GBRCAM, HER2-NEGATIVE HIGH RISK EARLY BREAST CA AND DOC. OF BEING PREVIOUSLY TREATED WITH CHEMOTX IN THE NEOADJUVANT OR ADJUVANT SETTING. 6)DX OF DELETERIOUS/SUSPECTED DELETERIOUS GBRCAM METASTATIC PANCREATIC ADENOCARCINOMA AND DOC. THAT MEMBER HAS NOT PROGRESSED ON AT LEAST 16 WEEKS OF A 1ST LINE PLATINUM-BASED CHEMOTX REGIMEN. 7)DX OF DELETERIOUS/SUSPECTED GERMLINE OR SOMATIC HOMOLOGOUS

RECOMBINATION REPAIR (HRR) GENE-MUTATED METASTATIC CASTRATION RESISTANT PROSTATE CANCER (MCRPC) AND DOC. OF PROGRESSION FOLLOWING TX W/ ENZALUTAMIDE OR ABIRATERONE AND THAT A GONADOTROPIN-RELEASING HORMONE (GNRH) ANALOG WILL BE USED CONCURRENTLY OR DOC. OF BILATERAL ORCHIECTOMY. 8)DX OF DELETERIOUS/SUSPECTED DELETERIOUS BRCA-MUTATED (BRCAm) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR DELETERIOUS/SUSPECTED DELETERIOUS BRCA-MUTATED (BRCAm) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC): DOCUMENTATION THAT LYNPARZA WILL BE USED IN COMBINATION WITH ABIRATERONE AND PREDNISONE OR PREDNISOLONE. FOR SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. FOR ADJUVANT TREATMENT OF HIGH-RISK EARLY BREAST CANCER: REQUESTS FOR TREATMENT BEYOND 1 YEAR WILL REQUIRE PEER-REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER’S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION. FOR FIRST-LINE MAINTENANCE OF BRCA-MUTATED ADVANCED OR HRD-POSITIVE ADVANCED OVARIAN CANCER: REQUESTS FOR TREATMENT BEYOND 2 YEARS WILL REQUIRE PEER-REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER’S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

LYRICA CR(GHP)

MEDICATION(S)
PREGABALIN ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical record documentation of one of the following: postherpetic neuralgia OR neuropathic pain associated with diabetic peripheral neuropathy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For postherpetic neuralgia: documentation of a therapeutic failure on, intolerance to, or contraindication to gabapentin and pregabalin. For neuropathic pain associated with diabetic peripheral neuropathy: documentation of a therapeutic failure on, intolerance to, or contraindication to duloxetine and pregabalin

LYTGOBI(GHP)

MEDICATION(S)
LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE LOCALLY ADVANCED OR METASTATIC CHOLANGIOCARCINOMA AND FIBROBLAST GROWTH FACTOR RECEPTOR 2 (FGFR2) FUSION OR OTHER REARRANGEMENT AS VERIFIED BY AN FDA-APPROVED TEST AND ONE PRIOR LINE OF THERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

MARGENZA(GHP)

MEDICATION(S)
MARGENZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HER2-POSITIVE BREAST CANCER AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH CHEMOTHERAPY AND DOCUMENTATION OF TWO OR MORE PRIOR ANTI-HER2 REGIMENS, AT LEAST ONE OF WHICH WAS FOR METASTATIC DISEASE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

MARQIBO(GHP)

MEDICATION(S)
MARQIBO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PHILADELPHIA CHROMOSOME-NEGATIVE (PH-) ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) IN SECOND OR GREATER RELAPSE OR WHOSE DISEASE HAS PROGRESSED FOLLOWING TWO OR MORE ANTI-LEUKEMIA THERAPIES.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VINCRISTINE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

MAVENCLAD(GHP)

MEDICATION(S)
MAVENCLAD (10 TABS), MAVENCLAD (4 TABS), MAVENCLAD (5 TABS), MAVENCLAD (6 TABS), MAVENCLAD (7 TABS), MAVENCLAD (8 TABS), MAVENCLAD (9 TABS)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of relapsing form of multiple sclerosis including relapsing-remitting disease and active secondary progressive disease.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
48 WEEKS

OTHER CRITERIA
Documentation that medication will be used as monotherapy, that requested dose is appropriate for the patient's weight, that patient has not been treated with more than three previous treatment cycles AND documentation of a therapeutic failure on, intolerance to, or contraindication to two formulary alternatives for the treatment of MS. Reauthorization will require documentation that patient has not received more than three previous cycles of Mavenclad for treatment of relapsing forms of multiple sclerosis (including relapsing-remitting disease and active secondary progressive disease) AND that member is not experiencing unacceptable toxicity or worsening of disease while on therapy.

MAVYRET(GHP)

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CRITERIA (INDICATION, DOSING, ETC.) WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. MEDICAL RECORD DOCUMENTATION OF A DIAGNOSIS OF HEPATITIS C INFECTION WITH IDENTIFICATION OF GENOTYPE AND SUBTYPE. DOCUMENTATION OF METAVIR LIVER FIBROSIS OR CIRRHOSIS ASSESSMENT BY A NON-INVASIVE TEST. DOCUMENTATION OF PREVIOUS TREATMENT AND TREATMENT RESPONSE. DOCUMENTATION OF RECEIVING THE FOLLOWING WITHIN THE PAST 6 MONTHS:HEPATIC FUNCTION PANEL, COMPLETE BLOOD COUNT, BASIC METABOLIC PANEL. DOCUMENTATION OF A BASELINE HCV RNA VIRAL LOAD. DOCUMENTATION OF NO LIMITED LIFE EXPECTANCY OF LESS THAN 12 MONTHS DUE TO NON LIVER RELATED COMORBID CONDITIONS.

AGE RESTRICTION
MUST BE 3 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BOARD CERTIFIED GASTROENTEROLOGIST, HEPATOLOGIST, INFECTIOUS DISEASE SPECIALIST OR TRANSPLANT SPECIALIST

COVERAGE DURATION
PER AASLD/IDSA GUIDELINES

OTHER CRITERIA
DOCUMENTATION OF ANY POTENTIAL DRUG INTERACTIONS THAT MAY IMPACT DRUG THERAPY ADDRESSED BY THE PRESCRIBER (SUCH AS DISCONTINUATION OF THE

INTERACTING DRUG, DOSE REDUCTION OF THE INTERACTING DRUG, OR COUNSELING OF THE RISKS ASSOCIATED WITH THE USE OF BOTH MEDICATIONS WHEN THEY INTERACT). DOCUMENTATION OF EITHER 1) COMPLETED HEPATITIS B SERIES OR 2) HEPATITIS B SCREENING (SAB, SAG AND CAB) AND QUANTITATIVE HEPATITIS B VIRUS (HBV) DNA IF POSITIVE FOR HEPATITIS B SAG AND EITHER DOCUMENTATION OF TREATMENT FOR HEPATITIS B IF THERE IS DETECTABLE HEPATITS B VIRUS OR DOCUMENTATION OF BEING VACCINATED AGAINST HEPATITIS B IF NEGATIVE FOR HEPATITIS B SAB. IF THE MEMBER IS 12 YEARS OF AGE AND OLDER OR WEIGHS MORE THAN 45 KG AND THE REQUEST IS FOR PACKETS: DOCUMENTATION OF WHY TABLET FORMULATION CANNOT BE USED.

MEBENDAZOLE(GHP)

MEDICATION(S)
EMVERM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of one of the following: Ancylostoma duodenale or Necator americanus (hookworms), Ascaris lumbricoides (roundworms), Enterobius vermicularis (pinworms), or Trichuris trichiura (whipworms)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 MONTH

OTHER CRITERIA
N/A

MEKINIST(GHP)

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic melanoma with one of the following: documentation of concurrent use with Tafinlar (dabrafenib) OR if being used as a single agent, documentation of no prior therapeutic failure with a BRAF inhibitor therapy (such as vemurafenib, dabrafenib, or encorafenib). Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test. Diagnosis of metastatic non-small cell lung cancer with concomitant use of Tafinlar AND documentation of BRAF V600E mutation as detected by an FDA approved test. Diagnosis of use for adjuvant treatment of melanoma with involvement of lymph nodes following complete resection AND documentation of concurrent use of Tafinlar (dabrafenib) AND documentation of BRAF V600E or V600K mutation. Diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND documentation of concurrent use of Tafinlar (dabrafenib) AND documentation of BRAF V600E mutation. Documentation of unresectable or metastatic solid tumors AND documentation of BRAF V600E mutation. Documentation of low-grade glioma (LGG) AND documentation of BRAF V600E mutation AND documentation of concurrent use of Tafinlar (dabrafenib).

AGE RESTRICTION
For LGG: age greater than or equal to one year and less than 18 years.

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

FOR UNRESECTABLE OR SOLID TUMORS, DOCUMENTATION OF PREVIOUS TREATMENT RESULTING IN DISEASE PROGRESSION AND DOCUMENTATION OF USE IN COMBINATION WITH TAFINLAR. REAUTHORIZATION BEYOND 12 MONTHS FOR ADJUVANT TREATMENT OF MELANOMA WILL REQUIRE LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND TEH FDA APPROVED TREATMENT DURATION. ALL OTHER REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

MEKTOVI(GHP)

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic melanoma AND documentation that medication is being prescribed in combination with Braftovi. Documentation of BRAF V600E OR V600K mutation as detected by an FDA approved test.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

MEPROBAMATE HRM(GHP)

MEDICATION(S)
MEPROBAMATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ANXIETY

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: BUSPIRONE, ESCITALOPRAM, OR VENLAFAXINE XR.

MEPSEVII(GHP)

MEDICATION(S)
MEPSEVII

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MUCOPOLYSACCHARIDOSIS VII (MPS VII, SLY SYNDROME) CONFIRMED BY THE FOLLOWING: 1) URINARY GLYCOSAMINOGLYCANS (GAGS) AT LEAST THREE TIMES THE UPPER LIMIT OF NORMAL, 2) ENZYME ACTIVITY ASSAY (BETA-GLUCURONIDASE DEFICIENCY) OR GENETIC TESTING (MUTATION OF CHROMOSOME 7Q21.11) 3) AT LEAST ONE OF THE FOLLOWING CLINICAL SIGNS OR SYMPTOMS: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTION OR PULMONARY DYSFUNCTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR GENETICIST WITH EXPERIENCE TREATING MUCOPOLYSACCHARIDOSIS

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
DOCUMENTATION OF A BASELINE EVALUATION, INCLUDING A STANDARDIZED ASSESSMENT OF MOTOR FUNCTION (I.E., 6-MINUTE WALK TEST, URINARY GAGS LEVEL, AND PULMONARY FUNCTION TEST). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF MEDICAL NECESSITY AND DOCUMENTATION OF IMPROVEMENT OR MAINTENANCE OF MOTOR FUNCTION, URINARY GAGS LEVEL, PULMONARY FUNCTION, OR OTHER CLINICAL SIGNS OR

SYMPTOMS (SUCH AS DECREASED LIVER/SPLEEN SIZE, IMPROVEMENT IN JOINT FUNCTION, ETC.)

MONJUVI(GHP)

MEDICATION(S)
MONJUVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) NOT OTHERWISE SPECIFIED, INCLUDING DLBCL ARISING FROM LOW GRADE LYMPHOMA AND DOCUMENTATION THAT MEMBER IS NOT ELIGIBLE FOR AUTOLOGOUS STEM CELL TRANSPLANT (ASCT) AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH LENALIDOMIDE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

MOTPOLY XR(GHP)

MEDICATION(S)
MOTPOLY XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of partial-onset seizures or primary generalized tonic-clonic seizures

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of member weight greater than or equal to 50 kilograms. Documentation of a therapeutic failure on, intolerance to, or contraindication to two formulary alternatives, one of which must be immediate release oral lacosamide.

MOUNJARO(GHP)

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Type 2 diabetes mellitus

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

MULPLETA(GHP)

MEDICATION(S)
MULPLETA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of thrombocytopenia in adult patients with chronic liver disease AND documentation of a platelet count less than 50 x 1000000000 (10 TO THE 9TH POWER)/L measured within the past 30 days. Documentation of a planned invasive procedure to be performed 8 to 14 days after initiation of treatment.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a hematologist, gastroenterologist, hepatologist, immunologist, transplant specialist, interventional radiologist, endocrinologist, or surgeon

COVERAGE DURATION
30 DAYS

OTHER CRITERIA
Documentation that the member is not receiving other TPO-Ras (i.e. romiplostin, eltrombopag). Documentation that the correct dose of medication is being used (3 mg orally once daily for 7 days). Documentation of a therapeutic failure on, intolerance to, or contraindication to Doptelet.

MYFEMBREE(GHP)

MEDICATION(S)
MYFEMBREE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS) OR DIAGNOSIS OF MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
GYNECOLOGIST

COVERAGE DURATION
24 MONTHS

OTHER CRITERIA
DOCUMENTATION OF PREMENOPAUSAL STATUS. FOR UTERINE LEIOMYOMAS: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO AT LEAST ONE PRIOR TREATMENT TO REDUCE MENSTRUAL BLEEDING, INCLUDING BUT NOT LIMITED TO: ORAL CONTRACEPTIVES OR ORAL PROGESTERONE OR TRANEXAMIC ACID OR GONADOTROPIN-RELEASING HORMONE (GNRH) AGONISTS. FOR ENDOMETRIOSIS: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE EXTENDED CYCLE CONTRACEPTIVE AND ONE FORMULARY NSAID. REQUESTS FOR REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT PATIENT HAS NOT BEEN TREATED FOR MORE THAN A TOTAL OF 24 MONTHS WITH A GNRH

RECEPTOR ANTAGONIST (SUCH AS RELUGOLIX OR ELAGOLIX) OR DOCUMENTATION OF MEDICAL OR SCIENTIFIC LITERATURE TO SUPPORT THE USE OF THIS AGENT BEYOND THE FDA-APPROVED TREATMENT DURATION.

MYLOTARG(GHP)

MEDICATION(S)
MYLOTARG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
NEWLY DIAGNOSED CD33-POSITIVE ACUTE MYELOID LEUKEMIA OR RELAPSED OR REFRACTORY CD33-POSITIVE ACUTE MYELOID LEUKEMIA

AGE RESTRICTION
RELAPSED OR REFRACTORY DX: 2 YEARS OF AGE OR OLDER. NEWLY DIAGNOSED: 1 MONTH OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
NEWLY DIAGNOSED PEDS: 6 MONTHS. ALL OTHERS: 12 MONTHS

OTHER CRITERIA
FOR NEWLY DIAGNOSED CD33-POSITIVE AML, AND AGE LESS THAN 18 YEARS OF AGE: DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH STANDARD CHEMOTHERAPY. REQUESTS FOR REAUTHORIZATION WILL BE BASED ON MEDICAL NECESSITY AND WILL REQUIRE DOCUMENTATION THAT MAXIMUM TREATMENT DURATION HAS NOT BEEN EXCEEDED OR PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

NAGLAZYME(GHP)

MEDICATION(S)
NAGLAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF MUCOPOLYSACCHARIDOSIS VI (MAROTEAUX-LAMY DISEASE)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

NATPARA(GHP)

MEDICATION(S)
NATPARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM AND DOCUMENTATION OF NO INCREASED BASELINE RISK FOR OSTEOSARCOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION SUPPORTING THE CONTINUED USE OF THE LOWEST DOSE THAT ACHIEVES A TOTAL SERUM CALCIUM (ALBUMIN CORRECTED) WITHIN THE LOWER HALF OF THE NORMAL TOTAL SERUM CALCIUM RANGE

NERLYNX(GHP)

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of early stage (Stages 1-3A) breast cancer AND documentation of HER-2 overexpression or amplification AND documentation of prior treatment with trastuzumab based therapy. Diagnosis of advanced or metastatic HER2-positive breast cancer used in combination with capecitabine AND documentation of trial of two or more prior anti-HER2 based regimens given in the metastatic setting.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorization for advanced or metastatic breast cancer will require documentation of continued disease improvement or lack of disease progression

NEULASTA(GHP)

MEDICATION(S)
NEULASTA ONPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME. HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME (H-ARS) WITH DOCUMENTATION OF AN ACUTE EXPOSURE TO MYELOSUPRESSIVE DOSES OF RADIATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE,

BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CRCL LESS THAN 50 ML/MIN).

NEXAVAR(GHP)

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR AN FDA APPROVED INDICATION OR A MEDICALLY ACCEPTED INDICATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

NEXIUM IV(GHP)

MEDICATION(S)
ESOMEPRAZOLE SODIUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PANTOPRAZOLE IV.

NEXVIAZYME(GHP)

MEDICATION(S)
NEXVIAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF LATE-ONSET POMPE DISEASE SUPPORTED BY AN ACID ALPHA-GLUCOSIDASE (GAA) ASSAY PERFORMED ON DRIED BLOOD SPOTS, SKIN FIBROBLASTS OR MUSCLE BIOPSY AND GENETIC TESTING SHOWING A MUTATION IN THE GAA GENE.

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR BIOCHEMICAL GENETICIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF BASELINE PULMONARY FUNCTION TESTING AND MUSCLE STRENGTH EVALUATION (I.E., PERCENT-PREDICTED FORCED VITAL CAPACITY (%FVC), 6-MINUTE WALK TEST (6MWT), GSGC (GAIT STAIRS, GOWER, CHAIR)). DOCUMENTATION OF RECEIVING AN APPROPRIATE DOSE BASED ON PATIENTS WEIGHT. DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH OTHER ENZYME REPLACEMENT THERAPY (I.E. LUMIZYNE). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OR STABILIZATION IN PULMONARY FUNCTION TESTING AND/OR MUSCLE STRENGTH EVALUATION AND DOCUMENTATION OF RECEIVING AN APPROPRIATE DOSE BASED ON PATIENTS WEIGHT AND DOCUMENTATION THAT MEDICATION IS NOT BEING USED IN

COMBINATION WITH OTHER ENZYME REPLACEMENT THERAPY (I.E. LUMIZYME).

NINLARO(GHP)

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA AND DOCUMENTATION OF MEDICATION BEING USED IN COMBINATION WITH REVLIMID AND DEXAMETHASONE. DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

NITYR(GHP)

MEDICATION(S)
NITYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HEREDITARY TYROSINEMIA TYPE 1 (HT-1). DOCUMENTATION OF ELEVATED PLASMA OR URINE SUCCINYLACETONE (SA) LEVELS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST OR GENETICIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

NOCDURNA(GHP)

MEDICATION(S)
NOCDURNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
History of hyponatremia or serum sodium less than 135 mEq/L. GFR less than 50 ml/min. Diagnosis of syndrome of inappropriate antidiuretic hormone (SIADH), New York Heart Association (NYHA) class II-IV congestive heart failure, or uncontrolled hypertension.

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of nocturia due to nocturnal polyuria, as defined by a night-time urine production exceeding one-third of the 24-hour urine production confirmed with a 24-hour urine frequency/volume chart AND documentation of waking at least two times per night to void.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
Documentation that medication is not being used in combination with a loop diuretic or systemic or inhaled glucocorticoid. Reauthorization will require documentation of clinical benefit AND documentation of none of the following: hyponatremia, GFR less than 50 ml/min, SIADH, class II-IV NYHA CHF, uncontrolled hypertension or use of loop diuretics or systemic or inhaled glucocorticoids.

NORTHERA(GHP)

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF SYMPTOMATIC NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) CAUSE BY ONE OF THE FOLLOWING: PRIMARY AUTONOMIC FAILURE, DOPAMINE BETA-HYDROXYLASE DEFICIENCY OR NON-DIABETIC AUTONOMIC NEUROPATHY

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
CARDIOLOGIST OR NEUROLOGIST

COVERAGE DURATION
4 WEEKS INITIAL AND 3 MONTHS CONTINUATION

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO MIDODRINE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED OR SUSTAINED IMPROVEMENT IN THE SYMPTOMS OF NOH.

NOURIANZ(GHP)

MEDICATION(S)
NOURIANZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Parkinson's disease with 'OFF' episodes or motor fluctuations AND documentation that medication will be used as adjunctive treatment to carbidopa-levodopa

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with a neurologist

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES FOR THE TREATMENT OF PARKINSONS DISEASE (INCLUDING BUT NOT LIMITED TO ORAL DOPAMINE AGONISTS, CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS, AND MONOAMINE OXIDASE TYPE B (MAO-B) INHIBITORS).

NOXAFIL(GHP)

MEDICATION(S)
NOXAFIL 300 MG PACKET, NOXAFIL 300 MG/16.7ML SOLUTION, POSACONAZOLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS IN SEVERELY IMMUNOCOMPROMISED PATIENTS (HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) RECIPIENTS WITH GRAFT-VERSUS-HOST-DISEASE (GVHD) OR THOSE WITH HEMATOLOGIC MALIGNANCIES WITH PROLONGED NEUTROPENIA FROM CHEMOTHERAPY) OR DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS OR TREATMENT OF INVASIVE ASPERGILLOSIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
OROPHARYNGEAL CANDIDA: 1 MONTH. ASPERGILLOSIS TX: 12 WEEKS. PROPHYLAXIS: 6 MONTHS

OTHER CRITERIA
For oropharyngeal candidiasis: failure on, intolerance to, or contraindication to fluconazole. Reauthorization for prophylaxis of invasive Aspergillus and Candida infections beyond 6 months will require documentation of medical necessity and continued disease risk from neutropenia or immunosuppression.

NPLATE(GHP)

MEDICATION(S)
NPLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF IMMUNE THROMBOCYTOPENIA PURPURA (ITP). DOCUMENTATION OF HEMATOPOIETIC SYNDROME OF ACTUE RADIATION SYNDROM (HS-ARS).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
HS-ARS: ONE TIME AUTH. ITP: 3 MONTHS INITIAL, 6 MONTHS CONTINUATION

OTHER CRITERIA
FOR HS-ARS: DOCUMENTATION OF SUSPECTED OR CONFIRMED ACUTE EXPOSURE TO MYELOSUPPRESSIVE DOSES OF RADIATION (ESTIMATED AS RADIATION LEVELS GREATER THAN 2 GRAY (GY)). FOR ITP: ONE OF THE FOLLOWING, 1)DOCUMENTATION OF SYMPTOMATIC ITP WITH BLEEDING SYMTPOMS WITH PLATELET COUNT LESS THAN 30,000/MICROL OR 2)DOCUMENTED HISTORY OF SIGNIFICANT BLEEDING WITH A PLATELET COUNT OF LESS THAN 30,000/MICROL OR 3)PLATELET COUNT OF LESS THAN 20,000/MICROL. FOR ITP: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CORTICOSTEROIDS AND ELTROMBOPAG. SUBSEQUENT APPROVAL AFTER 3 MONTHS WILL REQUIRE DOCUMENTATION OF MEDICAL NECESSITY SUCH AS A PLATELET COUNT NECESSARY TO REDUCE THE RISK FOR BLEEDING OR A HEMATOLOGICAL RESPONSE.

NUBEQA(GHP)

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of non-metastatic, castration-resistant prostate cancer. Diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC) AND documenation of use in combination with docetaxel.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF CONCURRENT USE WITH A GnRH ANALOG or THAT PATIENT HAS HAD A BILATERAL ORCHIECTOMY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

NUCALA(GHP)

MEDICATION(S)
NUCALA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SEVERE EOSINOPHILIC ASTHMA AND DOCUMENTATION THAT MEDICATION IS BEING USED AS ADD-ON MAINTENANCE TREATMENT AND DOCUMENTAION OF A BLOOD EOSINOPHIL COUNT OF 300 CELLS/MCL OR GREATER DURING THE 12 MONTH PERIOD BEFORE SCREENING OR 150 CELLS/MCL OR GREATER WITHIN 3 MONTHS OF THE THE START OF THERAPY OR DIAGNOSIS OF EOSINOPHILIC GRANULOMATOSIS (EGPA) CONFIRMED BY BIOPSY EVIDENCE OF VASCULITIS AND 4 OR MORE OF THE FOLLOWING CRITERIA: ASTHMA, EOSINOPHILIA, MONONEUROPATHY OR POLYNEUROPATHY, MIGRATORY OR TRANSIENT PULMONARY OPACITIES DETECTED RADIOGRAPHICALLY, PARANASAL SINUS ABNORMALITY OR BIOPSY CONTAINING A BLOOD VESSEL SHOWING THE ACCUMULATION OF EOSINOPHILS IN EXTRAVASCULAR AREAS. DIAGNOSIS OF HYPEREOSINOPHILIC SYNDROME (HES) FOR GREATER THAN OR EQUAL TO 6 MONTHS AND DOCUMENTATION THAT MEMBER HAS BEEN EVALUATED FOR AND DOES NOT HAVE AN IDENTIFIABLE NON-HEMATOLOGIC SECONDARY CAUSE OR FIP1 LIKE 1-PLATELET DERIVED GROWTH FACTOR RECEPTOR (FIP1L1-PDGFRALPHA) KINASE-POSITIVE HES. DIAGNOSIS OF CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSwNP) AND DOCUMENTATION OF USE AS ADD-ON MAINTENANCE TREATMENT.

AGE RESTRICTION
ASTHMA:6 YEARS OF AGE OR OLDER. EGPA OR CRSwNP:18 YEARS OR OLDER. HES:12 YEARS OR OLDER

PRESCRIBER RESTRICTION
FOR ASTHMA: ALLERGIST, IMMUNOLOGIST, PULMONOLOGIST. FOR EGPA: ALLERGIST,

IMMUNOLOGIST, PULMONOLOGIST, OR RHEUMATOLOGIST. FOR CRSWNP: BY OR IN CONSULTATION WITH ALLERGIST, PULMONOLOGIST OR OTOLARYNGOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT NUCALA IS NOT BEING USED IN COMBINATION WITH DUPILUMAB, OMALIZUMAB, BENRALIZUMAB, TEZEPELUMAB OR RESLIZUMAB. FOR EOSINOPHILIC ASTHMA: DOCUMENTATION OF CONTRAINDICATION, INTOLERANCE TO, OR POORLY CONTROLLED SYMPTOMS DESPITE AT LEAST A 30 DAY TRIAL OF MAXIMALLY TOLERATED INHALED CORTICOSTEROIDS AND/OR ORAL SYSTEMIC CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST OR TWO OR MORE EXACERBATIONS IN THE PREVIOUS 12 MONTHS REQUIRING ADDITIONAL MEDICAL TREATMENT (ORAL CORTICOSTEROIDS, EMERGENCY DEPARTMENT OR URGENT CARE VISITS, OR HOSPITALIZATION) DESPITE CURRENT THERAPY OR INTOLERANCE TO INHALED CORTICOSTEROIDS PLUS A LONG-ACTING BETA AGONIST. FOR EGPA: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO SYSTEMIC GLUCOCORTICOID THERAPY AND AT LEAST ONE IMMUNOSUPPRESSANT THRAPY (I.E. CYCLOPHOSPHAMIDE, AZATHIOPRINE, METHOTREXATE). FOR HES: (1)DOCUMENTATION OF A BLOOD EOSINOPHIL COUNT OF 1000 CELLS/MCL OR HIGHER AND (2)DOCUMENTATION OF AT LEAST TWO HES FLARES WITHIN THE PREVIOUS 12 MONTHS WITH A WORSENING OF CLINICAL SYMPTOMS OF HES OR INCREASING BLOOD EOSINOPHIL LEVELS REQUIRING AN ESCLATION IN THERAPY AND (3)DOCUMENTATION THAT MEMBER IS ON STABLE HES THERAPY INCLUDING, BUT NOT LIMITED TO ORAL CORTICOSTEROIDS, IMMUNOSUPPRESSIVES OR CYCTOXIC THERAPY. FOR CRSWNP: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO INTRANASAL CORTICOSTEROIDS. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

NUEDEXTA(GHP)

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PSEUDOBULBAR AFFECT

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

NULIBRY(GHP)

MEDICATION(S)
NULIBRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MOLYBDENUM COFACTOR DEFICIENCY (MOCD) TYPE A AS CONFIRMED BY GENETIC TESTING INDICATING A MUTATION IN THE MOLYBDENUM COFACTOR SYNTHESIS GENE 1 (MOSC1) GENE OR DOCUMENTATION OF BOTH OF THE FOLLOWING: 1) DOCUMENTATION OF BIOCHEMICAL AND CLINICAL FEATURES CONSISTENT WITH A DIAGNOSIS OF MOLYBDENUM COFACTOR DEFICIENCY (MOCD) TYPE A, INCLUDING BUT NOT LIMITED TO ENCEPHALOPATHY, INTRACTABLE SEIZURES, ELEVATED URINARY S-SULFOCYSTEINE LEVELS, AND DECREASED URIC ACID LEVELS AND 2) DOCUMENTATION THAT THE MEMBER WILL BE TREATED PRESUMPTIVELY WHILE AWAITING GENETIC CONFIRMATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEONATOLOGIST, GENETICIST OR PEDIATRIC NEUROLOGIST

COVERAGE DURATION
PRESUMPTIVE DX: 1 MONTH. CONFIRMED DX: 12 MONTHS.

OTHER CRITERIA
REAUTHORIZATION FOLLOWING INITIAL PRESUMPTIVE DIAGNOSIS WILL REQUIRE DOCUMENTATION OF GENETIC TESTING CONFIRMING A DIAGNOSIS OF MOLYBDENUM COFACTOR DEFICIENCY (MOCD) TYPE A. REAUTHORIZATION FOR GENETICIALLY

CONFIRMED MOCD TYPE A WILL REQUIRE DOCUMENTATION OF A CLINICALLY SIGNIFICANT POSITIVE RESPONSE OR LACK OF DISEASE PROGRESSION WHILE ON THERAPY.

NULOJIX(GHP)

MEDICATION(S)
NULOJIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RENAL TRANSPLANT

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF EPSTEIN-BARR VIRUS (EBV) SEROPOSITIVITY

NUPLAZID(GHP)

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of Parkinson's disease psychosis (defined by illusions, a false sense of presence, hallucinations, or delusions) established by or in consultation with a neurologist AND documentation that psychosis is not due to other conditions (which may include, but are not limited to, another mental disorder or physiological effects of a substance)

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
SUBSEQUENT APPROVALS WILL REQUIRE DOCUMENTATION OF CLINICAL IMPROVEMENT OR LACK OF PROGRESSION IN SIGNS AND SYMPTOMS OF PARKINSON'S DISEASE PSYCHOSIS.

NURTEC(GHP)

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MIGRAINE WITH OR WITHOUT AURA. DOCUMENTATION OF USE FOR THE ACUTE TREATMENT OF MIGRAINE OR DOCUMENTATION OF USE FOR THE PREVENTION OF EPISODIC MIGRAINE (DEFINED AS NO MORE THAN 14 HEADACHE DAYS PER MONTH).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Acute treatment: remainder of contract year: Migraine prevention: 6 month initial, 12 month reauth

OTHER CRITERIA
FOR MIGRAINE TREATMENT: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY TRIPTANS (E.G., ALMOTRIPTAN, NARATRIPTAN, RIZATRIPTAN, SUMATRIPTAN, ZOLMITRIPTAN). DOCUMENTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP ANTAGONIST INDICATED FOR THE ACUTE TREATMENT OF MIGRAINE. FOR MIGRAINE PREVENTION: DOCUMENTATION OF THE NUMBER OF BASELINE MIGRAINE OR HEADACHE DAYS PER MONTH AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING: ONE BETA BLOCKER (METOPROLOL, PROPRANOLOL, TIMOLOL, ANTENOLOL, NADOLOL), TOPIRAMATE,

DIVALPROEX OR SODIUM VALPROATE, AMITRIPTYLINE, VENLAFAXINE. DOCUMENTATION OR ATTESTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF BEING USED IN COMBINATION ATTESTATION OF THE FOLLOWING: THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND ATTESTATION OF A THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST. ATTESTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP RECEPTOR ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE. REAUTHORIZATION FOR MIGRAINE PREVENTION WILL REQUIRE ATTESTATION OF CONTINUED OR SUSTAINED REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OR A DECREASE IN SEVERITY OR DURATION OF MIGRAINE AND EITHER ATTESTATION THAT THE MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF THE REQUEST IS FOR COMBINATION USE WITH BOTOX ATTESTATION OF THE FOLLOWING: PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND ATTESTATION OF A PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST AND ATTESTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP RECEPTOR ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE.

NUVIGIL(GHP)

MEDICATION(S)
ARMODAFINIL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME, NARCOLEPSY OR SHIFT-WORK

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

NUZYRA(GHP)

MEDICATION(S)
NUZYRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of the following: Staphylococcus aureus (including methicillin-resistant (MRSA) and methicillin-susceptible (MSSA) isolates), Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus Group (including S. anginosus, S. intermedius, and S. constellatus), Enterococcus faecalis, Enterobacter cloacae and Klebsiella pneumoniae OR Diagnosis of community acquired bacterial pneumonia caused by susceptible isolates of the following: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible (MSSA) isolates), Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophilia, Mycoplasma pneumoniae, and Chlamydophila pneumoniae.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA
Documentation of culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments OR a documented history of previous intolerance to or contraindication to two other antibiotics shown to be susceptible on the culture and sensitivity OR documentation that therapy

was initiated during an inpatient setting.

OCREVUS(GHP)

MEDICATION(S)
OCREVUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PRIMARY PROGRESSIVE MS OR DIAGNOSIS OF A RELAPSING FORM OF MS (INCLUDING CLINICALLY ISOLATED SYNDROME, RELAPSING-REMITTING DISEASE, AND ACTIVE SECONDARY PROGRESSIVE DISEASE).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF HEPATITIS B SCREENING. FOR RELAPSING FORM OF MS: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO , OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT IN SIGNS AND SYMPTOMS OR MAINTENANCE OF CONDITION WHILE ON THERAPY.

ODOMZO(GHP)

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC) THAT HAS RECURRED FOLLOWING SURGERY OR RADIATION THERAPY OR THOSE WHO ARE NOT CANDIDATES FOR SURGERY OR RADIATION THERAPY. DOCUMENTATION THAT TREATMENT IS SUPPORTED BY MULTIDISCIPLINARY BOARD CONSULTATION PER NCCN GUIDELINES.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

OFEV(GHP)

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF IDIOPATHIC PULMONARY FIBROSIS (IPF) CONFIRMED BY EITHER A USUAL INTERSTITIAL PNEUMONIA PATTERN ON HIGH RESOLUTION CT SCAN OR BOTH HRCT AND SURGICAL LUNG BIOPSY PATTERN SUGGESTIVE OF IPF OR PROBABLE IPF MADE BY AN INTERDISCIPLINARY TEAM INCLUDING, BUT NOT LIMITED TO SPECIALISTS FROM PULMONARY MEDICINE, RADIOLOGY, THORACIC SURGERY, PATHOLOGY OR RHEUMATOLOGY AND DOCUMENTATION THAT THERE ARE NO OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE SUCH AS DOMESTIC AND OCCUPATIONAL ENVIRONMENTAL EXPOSURES, CONNECTIVE TISSUE DISEASE OR DRUG TOXICITY AND DOCUMENTATION THAT THE PATIENT WAS TAUGHT PULMONARY REHABILITATION TECHNIQUES. Diagnosis of systemic sclerosis according to American College of Rheumatology (ACR) and European League Against Rheumatism (EULAR) AND documentation of related interstitial lung disease confirmed by: 1) greater than or equal to 10 % fibrosis on a chest high resolution CT scan, 2) FVC greater than or equal to 40% of predicted normal, and 3) DLCO (diffusion capacity of the lung for carbon monoxide) 30-89% of predicted normal. Diagnosis of chronic fibrosing interstitial lung disease (ILDs) with a progressive phenotype AND documentation of ILD confirmed by all of the following: 1)10% or more fibrosis on a chest high resolution computer tomography AND 2) FVC more than 45% of predicted normal AND 3) Diffusion capacity of the lung for carbon monoxide (DLCO) of 30-80% of predicted normal.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PULMONOLOGIST or RHEUMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF ILD PROGRESSION WITH DOCUMENTATION OF THE FOLLOWING: 1) FVC DECLINE OF 10% OR GREATER OR 2)FVC DECLINE BETWEEN 5-10% WITH DOCUMENTATION OF WORSENING SYMPTOMS OR INCREASING FIBROTIC CHANGES ON IMAGING OR 3) DOCUMENTATION OF BOTH WORSENING SYMPTOMS AND INCREASING FIBROTIC CHANGES ON IMAGING.

OGSIVEO(GHP)

MEDICATION(S)
OGSIVEO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF DESMOID TUMORS WITH DOCUMENTATION OF PROGRESSION AND DOCUMENTATION THAT THE DESMOID TUMORS ARE NOT AMENABLE TO SURGERY AND REQUIRE SYSTEMIC TREATMENT.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

OJJAARA(GHP)

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS, INCLUDING PRIMARY MYELOFIBROSIS, POST-POLYCYTHEMIA VERA MYELOFIBROSIS OR POST-ESSENTIAL THROMBOCYTHEMIA MYELOFIBROSIS AND DOCUMENTATION OF TRANSFUSION-DEPENDENT ANEMIA ASSOCIATED WITH MYELOFIBROSIS (NOT FOR PATIENTS WITH SYMPTOMATIC SPLENOMEGALY ONLY) AND DOCUMENTATION OF BASELINE TOTAL SYMPTOM SCORE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH ANOTHER JANUS KINASE INHIBITOR. CONTINUED COVERAGE EVERY 6 MONTHS WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF RESPONSE TO THERAPY SUCH AS A REDUCTION FROM PRETREATMENT BASELINE SPLEEN VOLUME OR A REDUCTION IN THE TOTAL SYMPTOM SCORE FROM BASELINE AS MEASURED BY THE MODIFIED MYELOFIBROSIS

SYMPTOM ASSESSMENT FORM (MFSAF).

OLUMIANT(GHP)

MEDICATION(S)
OLUMIANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of moderate to severe Rheumatoid Arthritis made in accordance with the American College of Rheumatology criteria for the classification and diagnosis of Rheumatoid Arthritis. DIAGNOSIS OF SEVERE ALOPECIA AREATA (AA), DEFINED AS AT LEAST 50 PERCENT SCALP HAIR LOSS AS MEASURED BY THE SEVERITY OF ALOPECIA TOOL (SALT).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ) AND DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR CONTINUED THERAPY, DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION WHILE ON THERAPY.

ONIVYDE(GHP)

MEDICATION(S)
ONIVYDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF METASTATIC ADENOCARCINOMA OF THE PANCREAS AND DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH FLUOROURACIL AND LEUCOVORIN AND MEDICAL RECORD DOCUMENTATION OF DISEASE PROGRESSION FOLLOWING GEMCITABINE BASED THERAPY

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ONPATTRO(GHP)

MEDICATION(S)
ONPATTRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (HATTR) AS CONFIRMED BY GENETIC TESTING TO CONFIRM A PATHOGENIC MUTATION IN TTR AND ONE OF THE FOLLOWING: BIOPSY OF TISSUE OR ORGAN TO CONFIRM AMYLOID PRESENCE OR A CLINICAL MANIFESTATION TYPICAL OF HATTR (SUCH AS NEUROPATHY OR CHF) WITHOUT A BETTER ALTERNATIVE EXPLANATION. DOCUMENTATION OF MEDICATION BEING USED TO TREAT POLYNEUROPATHY. DOCUMENTATION OF FAMILIAL AMYLOID POLYNEUROPATHY (FAP) STAGE 1-2 OR POLYNEUROPATHY DISABILITY SCORE (PND) INDICATING THE PATIENT IS NOT WHEELCHAIR BOUND OR BEDRIDDEN.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with neurologist, board certified medical geneticist, or specialist with experience treating hATTR

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH OTHER RNA INTERFERENCE TREATMENTS. REAUTHORIZATION WILL REQUIRE MEDICAL NECESSITY AND NO DOCUMENTATION OF PROGRESSION TO FAP STAGE 3 AND NO DOCUMENTATION OF A

POLYNEUROPATHY DISABILITY SCORE INDICATING THE PATIENT IS WHEELCHAIR BOUND OR BEDRIDDEN.

ONUREG(GHP)

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of acute myeloid leukemia AND documentation that patient achieved first complete remission (CR) or complete remission with incomplete blood count recovery (Cri) following intensive induction chemotherapy AND documentation that patient is not able to complete intensive curative therapy.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

OPDIVO(GHP)

MEDICATION(S)
OPDIVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
UNRESECT/MET MELANOMA OR AS SINGLE AGENT IN ADJUVANT SETTING FOR COMPLETELY RESECTED STAGE IIB, IIC, III, OR IV MELANOMA. MET NSCLC AND 1)PROGRESSION ON/AFTER PLATINUM-BASED TX OR 2)PD-L1 OF AT LEAST 1% AND NO EGFR OR ALK GENOMIC TUMOR ABERRATIONS USED W/ YERVOY OR 3)NO EGFR OR ALK GENOMIC TUMOR ABERRATIONS USED FOR FIRST LINE TX W/ YERVOY AND 2 CYCLES OF PLATINUM-DOUBLET CHEMOTX. RESECTABLE NSCLC & MED WILL BE USED FOR NEOADJUVANT TX IN COMBO W/ PLATINUM-DOUBLET CHEMOTX. AS SINGLE AGENT FOR RELAPSED/SURGICALLY UNRESECT ADVANCED/MET RENAL CELL CARCINOMA (RCC) OR DX OF PREVIOUSLY UNTREATED ADVANCED RCC W/ ONE OF THE FOLLOWING: USED IN COMBO W/ IPILIMUMAB W/ INTERMEDIATE-POOR RISK (1 OR MORE PROGNOSTIC RISK FACTORS AS PER THE IMDC CRITERIA) OR USE IN COMBO W/ CABOZANTINIB. CLASSICAL HODGKIN LYMPHOMA (CHL) THAT HAS RELAPSED/PROGRESSED AFTER AUTOLOGOUS HSCT AND POST-TRANSPLANT BRENTUXIMAB OR AFTER 3 OR MORE LINES OF SYSTEMIC CHEMOTX THAT INCLUDES AUTOLOGOUS HSCT. RECURRENT MET SQUAMOUS CELL CARCINOMA OF THE HEAD & NECK W/ PROGRESSION ON/AFTER RECEIVING A PLATINUM-BASED TX. LOCALLY ADVANCED/MET UROTHELIAL CARCINOMA (UC) W/ EITHER PROGRESSION FOLLOWING PLATINUM TX OR WITHIN 12 MONTHS OF NEOADJUVANT/ADJUVANT TX W/ PLATINUM THERAPY OR FOR USE IN THE ADJUVANT SETTING WITH BOTH OF THE FOLLOWING: 1)RADIAL RESECTION OF UC AND 2)HIGH RISK OF RECURRENCE. MET COLORECTAL CANCER WITH MICROSATELLITE INSTABILITY HIGH (MSI-H) OR MISMATCH REPAIR AND PROGRESSION FOLLOWING TX W/ A FLUOROPYRIMIDINE, OXALIPLATIN, OR IRINOTECAN-BASED THERAPY AND USED AS MONOTHERAPY OR IN COMBO W/ IPILIMUMAB.

HEPATOCELLULAR CARCINOMA USED ALONE OR IN COMBO WITH IPILIMUMAB. UNRESECT ADVANCED, RECURRENT, OR MET ESOPHAGEAL SQUAMOUS CELL CARCINOMA (ESCC). ADJUVANT TREATMENT OF RESECTED ESOPHAGEAL OR GASTROESOPHAGEAL JUNCTION (GEJ) CANCER. GASTRIC CANCER, GEJ CANCER OR ESOPHAGEAL ADENOCARCINOMA. UNRESECT MALIGNANT PLEURAL MESOTHELIOMA WITH DOCUMENTATION OF USE IN COMBO W/ IPILIMUMAB.

AGE RESTRICTION
FOR MCRC AND MELANOMA MUST BE AT LEAST 12 YEARS OF AGE. ALL OTHERS: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 M, 12 M REAUTH.ADJ MELAN,GEJ,UC,RES NSCLC:6 M.1ST LINE NSCLC/MESOTH/ESOPH ADENOCA.6 M.18 M REAUTH

OTHER CRITERIA
FOR THE TREATMENT OF HCC: DOCUMENTATION OF A THERAPEUTIC FAILURE ON OR INTOLERANCE TO SORAFENIB. FOR THE TREATMENT OF NSCLC OR UROTHELIAL CARCINOMA, DOCUMENTATION THAT OPDIVO IS NOT BEING USED IN COMBINATION WITH ANY OTHER AGENTS. FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA, DOCUMENTATION THAT OPDIVO IS NOT BEING USED IN COMBINATION WITH ANY OTHER AGENT, EXCEPT IPILIMUMAB. FOR THE TREATMENT OF RENAL CELL CARCINOMA, DOCUMENTATION OF A THERAPEUTIC FAILURE OR INTOLERANCE TO ONE PRIOR ANTI-ANGIOGENIC THERAPY, INCLUDING BUT NOT LIMITED TO SUNITINIB, PAZOPANIB, AXITINIB, SORAFENIB, BEVACIZUMAB, EVEROLIUMS, OR TEMSIROLIMUS. FOR ESCC: 1)FOR UNRESECTABLE ADVANCED, RECURRENT OR METASTATIC DISEASE, DOCUMENTATION OF PREVIOUS TRIAL OF FLUOROPYRIMIDINE AND PLATINUM BASED THERAPY OR 2)DOCUMENTATION OF USE AS FIRST LINE THERAPY IN UNRESECTABLE ADVANCED OR METASTATIC DISEASE GIVEN IN COMBINATION WITH FLUOROPYRIMIDINE AND PLATINUM CONTAINING CHEMOTHERAPY or IN COMBINATION WITH IPILIMUMAB. FOR TREATMENT OF RESECTED ESOPHAGEAL OR GEJ CANCER: DOCUMENTATION OF COMPLETE RESECTION WITH RESIDUAL PATHOLOGIC DISEASE AND DOCUMENTATION THAT MEMBER HAS RECEIVED NEOADJUVANT CHEMORADIOTHERAPY AND DOCUMENATION THAT MEDICATION IS BEING USED AS A SINGLE AGENT IN THE ADJUVANT SETTING. FOR GASTRIC, GEJ AND ESOPHAGEAL ADENOCARCINOMA: DOCUMENTATION THAT MEDICATION WILL BE

USED IN COMBINATION WITH FLUOROPYRIMIDINE AND PLATINUM BASED CHEMOTHERAPY. SUBSEQUENT APPROVALS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REQUESTS BEYOND 12 MONTHS FOR ADJUVANT TREATMENT OF METASTATIC MELANOMA, ADJUVANT TREATMENT OF RESECTED ESOPHAGEAL OR GEJ CANCER, AND ADJUVANT UROTHELIAL CARCINOMA WILL REQUIRE PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

OPDUALAG(GHP)

MEDICATION(S)
OPDUALAG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR PATIENTS GREATER THAN 12 YEARS OF AGE AND LESS THAN 18 YEARS OF AGE: DOCUMENTATION OF WEIGHT GREATER THAN OR EQUAL TO 40 KG. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

OPSUMIT(GHP)

MEDICATION(S)
OPSUMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF WHO FUNCTIONAL CLASS II, III, OR IV PULMONARY ARTERIAL HYPERTENSION AND NEGATIVE PREGNANCY TEST IN FEMALES OF CHILDBEARING POTENTIAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION THAT OPSUMIT WILL BE USED IN COMBINATION WITH OR THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL

OPZELURA(GHP)

MEDICATION(S)
OPZELURA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF MILD TO MODERATE ATOPIC DERMATITIS (AD). DOCUMENTATION OF DIAGNOSIS OF NONSEGMENTAL VITILIGO.

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST

COVERAGE DURATION
FOR AD: 3 MONTHS INITIAL, 6 MONTHS CONTINUATION. FOR VITILIGO: 6 MONTHS INITIAL AND CONTINUATION.

OTHER CRITERIA
DOCUMENTATION THAT OPZELURA IS NOT BEING USED IN COMBINATION WITH THERAPEUTIC BIOLOGICS, OTHER JAK INHIBITORS OR POTENT IMMUNOSUPPRESSANTS SUCH AS AZATHIOPRINE OR CYCLOSPORINE. FOR AD: DOCUMENTATION THAT MEMBER IS IMMUNOCOMPETENT AND DOCUMENTATION OF BODY SURFACE AREA (BSA) LESS THAN OR EQUAL TO 20%. DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING: ONE FORMULARY TOPICAL CALCINEURIN INHIBITOR, ONE FORMULARY TOPICAL CORTICOSTEROID UNLESS DEEMED INADVISABLE DUE TO POTENTIAL RISKS SUCH AS USE ON SENSITIVE SKIN AREAS (FACE, AXILLAE, OR GROIN), OR EUCRISA. FOR VITILIGO: DOCUMENTATION OF BODY SURFACE

AREA (BSA) LESS THAN OR EQUAL TO 10% AND DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY TOPICAL CORTICOSTEROIDS UNLESS DEEMED INADVISABLE DUE TO POTENTIAL RISKS SUCH AS USE ON SENSITIVE SKIN AREAS (FACE, AXILLAE, OR GROIN). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF TOLERABILITY AND POSITIVE CLINICAL RESPONSE TO OPZELURA AND DOCUMENTATION THAT OPZELURA IS NOT BEING USED IN COMBINATION WITH THERAPEUTIC BIOLOGICS, OTHER JAK INHIBITORS OR POTENT IMMUNOSUPPRESSANTS SUCH AS AZATHIOPRINE OR CYCLOSPORINE AND DOCUMENTATION OF SYMPTOMATIC ATOPIC DERMATITIS THAT REQUIRES ADDITIONAL TREATMENT WITH OPZELURA OR DOCUMENTATION OF SYMPTOMATIC NONSEGMENTAL VITILIGO THAT REQUIRES ADDITIONAL TREATMENT WITH OPZELURA.

ORENCIA(GHP)

MEDICATION(S)
ORENCIA 125 MG/ML SOLN PRSYR, ORENCIA 50 MG/0.4ML SOLN PRSYR, ORENCIA 87.5 MG/0.7ML SOLN PRSYR, ORENCIA CLICKJECT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS or DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS or DIAGNOSIS OF PSORIATIC ARTHRITIS WHICH MUST INCLUDE DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS.

AGE RESTRICTION
FOR RA: MUST BE 18 YEARS OF AGE OR OLDER. FOR PJIA AND PSA: MUST BE 2 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: DOCUMENTATION OF AN INADEQUATE RESPONSE TO A 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS INDICATED FOR RA (HUMIRA, ENBREL, RINVOQ, XELJANZ). FOR PJIA: DOCUMENTATION OF AN INADEQUATE RESPONSE TO A 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR JIA (HUMIRA,

ENBREL, ACTEMRA SC, XELJANZ). FOR ADULT PSA: DOCUMENTATION OF AN INADEQUATE RESPONSE TO A 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PSA (ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA, RINVOQ, XELJANZ, COSENTYX). FOR PEDIATRIC (2 TO 17 YEARS OF AGE) PSA: DOCUMENTATION OF AN INADEQUATE RESPONSE TO A 3 MONTH TRIAL OF COSENTYX AND ENBREL. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ORGOVYX(GHP)

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of advanced prostate cancer.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

ORIAHNN(GHP)

MEDICATION(S)
ORIAHNN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS)

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
GYNECOLOGIST

COVERAGE DURATION
24 MONTHS

OTHER CRITERIA
DOCUMENTATION OF PREMENOPAUSAL STATUS. DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO AT LEAST ONE PRIOR TREATMENT TO REDUCE MENSTRUAL BLEEDING, INCLUDING BUT NOT LIMITED TO: ORAL CONTRACEPTIVES OR ORAL PROGESTERONE OR TRANEXAMIC ACID OR GONADOTROPIN-RELEASING HORMONE (GNRH) AGONISTS. REQUESTS FOR REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT PATIENT HAS NOT BEEN TREATED FOR MORE THAN A TOTAL OF 24 MONTHS WITH A GNRH RECEPTOR ANTAGONIST (SUCH AS RELUGOLIX OR ELAGOLIX) OR DOCUMENTATION OF MEDICAL OR SCIENTIFIC LITERATURE TO SUPPORT THE USE OF THIS AGENT BEYOND THE FDA-APPROVED TREATMENT DURATION.

ORILISSA(GHP)

MEDICATION(S)
ORILISSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of moderate to severe pain associated with endometriosis, which may include endometriosis-related dyspareunia

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
GYNECOLOGIST

COVERAGE DURATION
150 MG: 24 MONTHS. 200 MG: 6 MONTHS

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to one extended cycle contraceptive AND one formulary NSAID. Documentation that the patient has not been treated for more than a total of 24 months with Orilissa 150 mg daily OR more than a total of 6 months with Orilissa 200 mg twice daily OR documentation of medical or scientific literature to support the use of this agent beyond the FDA approved treatment duration.

ORKAMBI(GHP)

MEDICATION(S)
ORKAMBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CYSTIC FIBROSIS. DOCUMENTATION THAT THE MEMBER IS HOMOZYGOUS FOR THE F508DEL CFTR MUTATION AS DOCUMENTED BY AN FDA-CLEARED TEST.

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CYSTIC FIBROSIS SPECIALIST

COVERAGE DURATION
4 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OR STABILIZATION IN THE SIGNS AND SYMPTOMS OF CYSTIC FIBROSIS

ORLADEYO(GHP)

MEDICATION(S)
ORLADEYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HEREDITARY ANGIOEDEMA and FOR HAE TYPE I AND TYPE II: THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDMEA WITHOUT URTICARIA SUPPORTED BY DOCUMENTATION OF LOW C4 LEVELS AND LESS THAN 50 PERCENT OF THE LOWER LIMIT OF NORMAL C1-INH ANTIGENIC PROTEIN LEVELS OR FUNCTION LEVELS

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS BEING USED AS PROPHYLACTIC THERAPY. Documentation that medication is not being used in combination with another prophylactic human C1 esterase inhibitor (Cinryze or Haegarda) or lanadelumab (Takhzyro) therapy for hereditary angioedema. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ORSERDU(GHP)

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ER-POSITIVE, HER2-NEGATIVE, ESR1-MUTATED ADVANCED OR METASTATIC BREAST CANCER AND DOCUMENTATION THAT ORSERDU IS BEING PRESCRIBED IN POSTMENOPAUSAL WOMEN OR MEN AND DOCUMENTATION OF DISEASE PROGRESSION FOLLOWING AT LEAST ONE PRIOR ENDOCRINE THERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

OSPHENA(GHP)

MEDICATION(S)
OSPHENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MENOPAUSE AND DOCUMENTATION THAT MEMBER IS EXPERIENCING AT LEAST ONE OF THE FOLLOWING SYMPTOMS OF VULVAR AND VAGINAL ATROPHY (VVA): MODERATE TO SEVERE DYSPAREUNIA OR MODERATE TO SEVERE VAGINAL DRYNESS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY TOPICAL ESTRADIOL/CONJUGATED ESTROGEN PRODUCTS (E.G., CREAM, TABLET, RING).

OTEZLA(GHP)

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF ACTIVE PSORIATIC ARTHRITIS WHICH MUST INCLUDE DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS. DX OF PERIPHERAL PSA OR AXIAL PSA. DOCUMENTATION OF MILD PLAQUE PSORIASIS CHARACTERIZED BY LESS THAN 5% BODY SURFACE AREA. DOCUMENTATION OF MODERATE TO SEVERE PLAQUE PSORIASIS CHARACTERIZED BY 5% OR GREATER INVOLVEMENT OF BODY SURFACE AREA OR DISEASE INVOVLING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS. DIAGNOSIS OF ORAL ULCERS ASSOCIATED WITH BEHCET'S DISEASE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR MILD

PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 2 TOPICAL THERAPIES USED FOR THE TREATMENT OF PSORIASIS, ONE OF WHICH IS A CORICOSTEROID OF AT LEAST MEDIUM POTENCY. FOR MODERATE TO SEVERE PLAQUE PSORIASIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE OR PHOTOTHERAPY. FOR ALL INDICATIONS, FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION OF CLINICAL OR SUSTAINED IMPROVEMENT OF SIGNS AND SYMPTOMS OF DISEASE.

OXBRYTA(GHP)

MEDICATION(S)
OXBRYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of sickle cell disease.

AGE RESTRICTION
MUST BE 4 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a hematologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF BASELINE HEMOGLOBIN. IF 5 YEARS OF AGE OR OLDER: DOCUMENTATION OF INTOLERANCE TO, CONTRAINDICATION OR THERAPEUTIC FAILURE ON 3 MONTH TRIAL OF HYDROXYUREA AND ENDARI. IF LESS THAN 5 YEARS OF AGE: DOCUMENTATION OF INTOLERANCE TO, CONTRAINDICATION OR THERAPEUTIC FAILURE ON 3 MONTH TRIAL OF HYDROXYUREA. IF THE REQUESTED DOSE IS 2500 MG DAILY: DOCUMENTATION OF USING IN COMBINATION WITH A STRONG OR MODERATE CYP3A4 INDUCER, INCLUDING BUT NOT LIMITED TO APALUTAMIDE, BOSENTAN, CARBAMAZEPINE, EFAVIRENZ, ETRAVIRINE, ENZALUTAMIDE, NITOTANE, PHENOBARBITAL, PHENYOTIN, PRIMIDONE, RIFAMPIN OR ST. JOHN'S WORT. REAUTHORIZATION WILL REQUIRE AN INCREASE IN HEMOGLOBIN FROM BASELINE OR AN IMPROVEMENT IN COMPLICATIONS OF SICKLE CELL DISEASE (I.E., DECREASE IN VASOOCCLUSIVE CRISIS RELATED

EMERGENCIES), AND IF REQUESTING A DOSE OF 2500 MG DAILY, THAT MEDICATION IS BEING USED IN COMBINATION WITH A STRONG OR MODERATE CYP3A4 INDUCER.

OXERVATE(GHP)

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of neurotrophic keratitis (NK) as confirmed by a decrease or loss in corneal sensitivity AND one of the following: 1) superficial keratopathy, 2) persistent epithelial defects or 3) corneal ulcers.

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
OPHTHALMOLOGIST

COVERAGE DURATION
8 WEEKS

OTHER CRITERIA
REAUTHORIZATION FOR TREATMENT BEYOND 8 WEEKS WILL REQUIRE DOCUMENTATION OF MEDICAL OR SCIENTIFIC LITERATURE TO SUPPORT THE USE OF THIS AGENT BEYOND THE FDA APPROVED TREATMENT DURATION.

OXLUMO(GHP)

MEDICATION(S)
OXLUMO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PRIMARY HYPEROXALURIA TYPE 1 (PH1) AS CONFIRMD BY ONE OF THE FOLLOWING: MOLECULAR GENETIC TESTING THAT CONFIRMS A MUTATION OF ALANIN:GLYOXYLATE AMINOTRANSFERASE GENE (AGXT) OR A LIVER BIOPSY TO CONFIRM ABSENT OR SIGNIFICANTLY REDUCED ALANIN-GLYOXYLATE AMINOTRANSFERASE (AGT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SPECIALIST WITH EXPERIENCE MANAGING HYPEROXALURIA (I.E. NEPHROLOGIST, UROLOGIST, GENETICIST, HEPATOLOGIST)

COVERAGE DURATION
6 MONTHS INITIAL AND 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF METABOLIC SCREENING THAT DEMONSTRATES ONE OF THE FOLLOWING: MARKEDLY INCREASED URINARY OXALATE EXCRETION (I.E. GENERALLY GREATER THAN 0.7 MMOL/1.73M2/DAY OR GREATER THAN THE UPPER LIMIT OF NORMAL) OR INCREASED URINARY OXALATE TO CREATININE RATIO (I.E. GREATER THAN THE AGE-SPECIFIC UPPER LIMIT OF NORMAL). DOCUMENTATION OF SUFFICENT KINDEY FUNCTION AS DEFINED BY ONE OF THE FOLLOWING: DOCUMENTATION OF AN EGFR GREATER THAN OR EQUAL TO 30ML/MIN/1.73M2) OR IF EGFR IS NOT CALCULATED DUE TO AGE LIMITATIONS,

A SERUM CREATININE WITHIN THE NORMAL AGE-SPECIFIC REFERENCE RANGE. DOCUMENTATION THAT MEMBER DOES NOT HAVE A HISTORY OF LIVER TRANSPLANT. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION, CONTINUED ADEQUATE RENAL FUNCTION (GREATER THAN OR EQUAL TO 30 ML PER MIN) AND DOCUMENTATION OF NOT RECEIVING A LIVER TRANSPLANT.

PADCEV(GHP)

MEDICATION(S)
PADCEV

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER AND DOCUMENTATION OF ONE OF THE FOLLOWING: (1) THAT MEMBER HAS RECEIVED A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR, AND A PLATINUM-CONTAINING CHEMOTHERAPY OR (2) THAT MEMBER HAS RECEIVED AT LEAST ONE PRIOR LINE OF THERAPY AND IS INELIGIBLE FOR CISPLATIN-CONTAINING CHEMOTHERAPY OR (3) DOCUMENTATION THAT PADCEV WILL BE PRESCRIBED IN COMBINATION WITH KEYTRUDA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

PALYNZIQ(GHP)

MEDICATION(S)
PALYNZIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of phenylketonuria (PKU) AND documentation of phenylalanine (Phe) concentrations greater than 600 micromol/L on existing management.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT THE MEMBER HAS (OR WILL RECEIVE) A PRESCRIPTION FOR EPINEPHRINE AUTO-INJECTOR. DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO KUVAN. DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH KUVAN. REAUTHORIZATION WILL REQUIRE ONE OF THE FOLLOWING: DOCUMENTATION OF PRESCRIBER ASSESSED IMPROVEMENT IN NEUROPSYCHIATRIC SYMPTOMS OR AN INCREASE IN PHE TOLERANCE OR DOCUMENTATION OF A 20% REDUCTION IN PHE CONCENTRATION FROM BASELINE OR A BLOOD PHE CONCENTRATION LESS THAN 600 MICROMOL/L.

PANRETIN(GHP)

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CUTANEOUS LESIONS IN PATIENTS WITH AIDS RELATED KAPOSI'S SARCOMA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMINOSYN II, AMINOSYN-PF, AMINOSYN-PF 7%, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, ATGAM, AZASAN, AZATHIOPRINE 100 MG TAB, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 75 MG TAB, AZATHIOPRINE SODIUM, BLEOMYCIN SULFATE, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CLADRIBINE, CLINISOL SF, CLINOLIPID, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE 50 MG/ML SOLUTION, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE (PF), DEFEROXAMINE MESYLATE, DEXTROSE 10 % SOLUTION, DEXTROSE 20 % SOLUTION, DEXTROSE 250 MG/ML SOLUTION, DEXTROSE 40 % SOLUTION, DEXTROSE 50 % SOLUTION, DEXTROSE 70 % SOLUTION, DEXTROSE-SODIUM CHLORIDE 10-0.2 % SOLUTION, DEXTROSE-SODIUM CHLORIDE 10-0.45 % SOLUTION, DIPHTHERIA-TETANUS TOXOIDS DT, DOBUTAMINE HCL, DOBUTAMINE IN D5W, DOBUTAMINE-DEXTROSE, DOXORUBICIN HCL, ENGERIX-B, ENVARSUS XR, FLOXURIDINE 0.5 GM RECON SOLN, FLUOROURACIL 1 GM/20ML SOLUTION, FLUOROURACIL 2.5 GM/50ML SOLUTION, FLUOROURACIL 5 GM/100ML SOLUTION, FLUOROURACIL 500 MG/10ML SOLUTION, FOSCARNET SODIUM, GANCICLOVIR SODIUM, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IMOVAX RABIES, INSULIN ASPART, INTRALIPID, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, METHYLPREDNISOLONE 16 MG TAB, METHYLPREDNISOLONE 32 MG TAB, METHYLPREDNISOLONE 4 MG TAB, METHYLPREDNISOLONE 8 MG TAB, MILRINONE LACTATE, MILRINONE LACTATE IN DEXTROSE, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG RECON SOLN, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NOVOLOG, NOVOLOG RELION, NUTRILIPID, ONDANSETRON, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML

SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 25 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 6.7 (5 BASE) MG/5ML SOLUTION, PREDNISONE 1 MG TAB, PREDNISONE 10 MG TAB, PREDNISONE 2.5 MG TAB, PREDNISONE 20 MG TAB, PREDNISONE 5 MG TAB, PREDNISONE 5 MG/5ML SOLUTION, PREDNISONE 50 MG TAB, PREHEVBRIO, PREMASOL, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROGRAF 5 MG/ML SOLUTION, PROSOL, RABAVERT, RECOMBIVAX HB, SANDIMMUNE 100 MG/ML SOLUTION, SIMULECT, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TAB, SYNTHAMIN 17, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TDVAX, TENIVAC, TETANUS-DIPHTHERIA TOXOIDS TD, THYMOGLOBULIN, TRAVASOL, TROPHAMINE, VINBLASTINE SULFATE, VINCRISTINE SULFATE, YUPELRI

DETAILS

This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PEMAZYRE(GHP)

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of unresectable locally advanced or metastatic cholangiocarcinoma AND documentation of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as verified by an FDA approved test AND documentation of trial of one prior line of therapy.
DOCUMENTATION OF RELAPSED OR REFRACTORY MYELOID/LYMPHOID NEOPLASMS (MLNs) WITH FIBROBLAST GROWTH FACTOR RECEPTOR 1 (FGFR1) REARRANGEMENT.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

PEPAXTO(GHP)

MEDICATION(S)
PEPAXTO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA AND DOCUMENTATION OF TREATMEANT WITH AT LEAST 4 PRIOR THERAPIES AND ARE REFRACTORY TO AT LEAST ONE ANTI-CD38 MONOCLONAL ANTIBODY, ONE PROTEASOME INHIBITOR, AND ONE IMMUNOMODULATORY AGENT

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

PERFOROMIST(GHP)

MEDICATION(S)
FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF COPD

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SEREVENT OR DOCUMENTATION OF INABILITY TO USE AN INHALER.

PERSERIS(GHP)

MEDICATION(S)
PERSERIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of schizophrenia

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on or intolerance to the oral equivalent form of the medication.

PHENOXYBENZAMINE(GHP)

MEDICATION(S)
PHENOXYBENZAMINE HCL 10 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PHEOCHROMOCYTOMA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

PIQRAY(GHP)

MEDICATION(S)
PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of advanced or metastatic breast cancer that is hormone receptor-positive, HER2-negative (HR+/HER2-) AND documentation of a PIK3CA mutation determined using a FDA approved test.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to prior endocrine therapy AND documentation of use in combination with fulvestrant. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

POLIVY(GHP)

MEDICATION(S)
POLIVY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA, NOT OTHERWISE SPECIFIED AND DOCUMENTATION OF USE IN COMBINATION WITH BENDAMUSTINE AND RITUXIMAB AND DOCUMENTATION OF USE AS SUBSEQUENT THERAPY AFTER A TRIAL OF 2 OR MORE PRIOR THERAPIES. DIAGNOSIS OF PREVIOUSLY UNTREATED DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED OR HIGH-GRADE B-CELL LYMPHOMA (HGBL) AND DOCUMENTATION OF INTERNATIONAL PROGNOSTIC INDEX SCORE OF 2 OR GREATER AND DOCUMENATION THAT POLIVY WILL BE USED IN COMBINATION WITH RITUXIMAB, CYCLOPHOSPHAMIDE, DOXORUBICIN, AND PREDNISONE (R-CHP).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND DOCUMENTATION THAT THE FDA APPROVED TREATMENT DURATION (6, 21 DAY CYCLES) HAS NOT BEEN EXCEEDED.

TREATMENT BEYOND FDA APPROVED LABELING WILL REQUIRE DOCUMENTATION OF PEER REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

POMALYST(GHP)

MEDICATION(S)
POMALYST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA and DOCUMENTATION THAT POMALYST IS BEING PRESCRIBED IN COMBINATION WITH DEXAMETHASONE OR DOCUMENTATION THAT THE PATIENT IS STEROID INTOLERANT. Documentation of Kaposi sarcoma with one of the following: 1) AIDS-related Kaposi sarcoma with documentation of progression despite the use of antiretroviral therapy AND documentation that antiretroviral therapy will be continued OR 2) documentation of HIV-negative status.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For Multiple Myeloma: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PRIOR THERAPIES: BORTEZOMIB (VELCADE) AND LENALIDOMIDE (REVLIMID). REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

PORTRAZZA(GHP)

MEDICATION(S)
PORTRAZZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF METASTATIC SQUAMOUS NON-SMALL CELL LUNG CANCER AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH GEMCITABINE AND CISPLATIN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF DISEASE PROGRESSION OR AN INTOLERANCE TO ONE ALTERNATIVE CATEGORY 1 OR CATEGORY 2 RECOMMENDED REGIMEN PER NCCN GUIDELINES. SUBSEQUENT APPROVAL AFTER 6 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

PRALUENT(GHP)

MEDICATION(S)
PRALUENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD), INCUDING ACUTE CORONARY SYNDROMES (A HX OF MI OR UNSTABLE ANGINA), CORONARY OR OTHER ARTERIAL REVASCULARIZATION, STROKE TIA OR PAD PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN. PRIMARY HYPERLIPIDEMIA. HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) WITH ONE OF THE FOLLOWING: GENETIC TESTING TO CONFIRM MUTATION IN THE LDL RECEPTOR, PCSK9, OR APOB GENE OR DX OF DEFINITE HEFH (SCORE GREATER THAN 8) ON THE DUTCH LIPID CLINIC NETWORK DIAGNOSTIC CRITERIA. FOR HOFH ONE OF THE FOLLOWING: GENETIC TESTING TO CONFIRM DIAGNOSIS SHOWING AT LEAST ONE LOW-DENSITY LIPOPROTEIN (LDL) RECEPTOR-DEFECTIVE MUTATION OR DX MADE BASED ON HISTORY OF AN UNTREATED LDL-C GREATER THAN 500 MG/DL AND EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) IN BOTH PARENTS. DOCUMENTATION OF A BASELINE LDL DRAWN WITHIN 3 MONTHS OF THE START OF PCSK9 THERAPY SHOWING AN LDL GREATER THAN 100 IF USING FOR PRIMARY PREVENTION OR AN LDL GREATER THAN 70 IF USING FOR SECONDARY PREVENTION. DOCUMENTATION THAT PRALUENT IS NOT BEING USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR. FOR STATIN TOLERANT PATIENTS, DOCUMENTATION OF AN INABILITY TO ACHIEVE AND MAINTAIN LDL GOAL WITH ONE OF THE FOLLOWING (1) MAXIMUM TOLERATED DOSE OF A HIGH INTENSITY STATIN (ATORVASTATIN 40 MG OR HIGHER OR ROSUVASTATIN 20 MG OR HIGHER) OR (2) A MAXIMALLY TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT HAS HAD A PREVIOUS TRIAL OF EITHER ATORVASTATIN OR ROSUVASTATIN, WITH PRESCRIBERS DOCUMENTATION REGARDING LENGTH OF PREVIOUS TRIALS OF STATINS.

PATIENT MUST INTEND TO CONTINUE ON MAXIMAL STATIN THERAPY ONCE PRALUENT IS STARTED. FOR STATIN INTOLERANT PATIENTS, DOCUMENTATION OF REASON FOR STATIN INTOLERANCE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
THERAPEUTIC FAILURE IS DEFINED AS AN INABILITY TO REACH TARGET LDL GOALS (LESS THAN 100 MG/DL FOR PATIENTS WITH HEFH IN PRIMARY PREVENTION OR LESS THAN 70 MG/DL FOR ASCVD OR FOR PATIENTS WITH HEFH USING PRALUENT AS SECONDARY PREVENTION) DESPITE AT LEAST A 3 MONTH TRIAL. INTOLERANCE TO STATINS IS DEFINED AS INCREASED LFTS, INTOLERABLE MYALGIA (MUSCLE SYMPTOMS WITHOUT CREATININE KINASE (CK) ELEVATIONS) OR MYOPATHY (MUSCLE SYMPTOMS WITH CK ELEVATIONS), OR MYOSITIS (ELEVATIONS IN CK WITHOUT MUSCLE SYMPTOMS), WHICH PERSIST AFTER RETRIAL WITH A DIFFERENT DOSE OR DIFFERENT DOSING STRATEGY (EVERY OTHER DAY) OF ALTERNATIVE MODERATE- OR HIGH-INTENSITY STATIN. CONTRAINDICATIONS TO STATINS ARE DEFINED AS ACTIVE LIVER DISEASE, PREVIOUS HISTORY OF RHABDOMYOLYSIS, OR HYPERSENSITIVITY. RENEWAL CRITERIA: DOCUMENTATION OR PRESCRIBER ATTESTATION OF CLINICALLY SIGNIFICANT RESPONSE TO TREATMENT AND DOCUMENTATION OF NO SIGNIFICANT ADVERSE EVENTS RELATED TO THERAPY AND DOCUMENTATION OF STILL TAKING STATIN (IF STATIN TOLERANT) AND DOCUMENTATION THAT PRALUENT CONTINUES TO NOT BE USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR.

PRETOMANID(GHP)

MEDICATION(S)
PRETOMANID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of pulmonary infection due to Mycobacterium tuberculosis AND either documentation of extensively drug resistant tuberculosis OR treatment-intolerant or nonresponsive multidrug-resistant tuberculosis.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with a physician specializing in infection disease

COVERAGE DURATION
26 WEEKS

OTHER CRITERIA
Documentation that medication will be used in combination with bedaquiline and linezolid.

PREVYMIS(GHP)

MEDICATION(S)
PREVYMIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation that the member is a recipient of an allogeneic hematopoietic stem cell transplant AND documentation that member is a confirmed CMV seropositive recipient (R+) AND documentation that medication is being used for CMV prophylaxis AND therapy is being initiated between Day 0 and Day 28 post-transplantation. DOCUMENTATION THAT MEMBER IS A RECIPIENT OF A KIDNEY TRANSPLANT AND DOCUMENTATION THAT MEMBER IS AT HIGH RISK OF CMV (DEFINED AS CMV SEROPOSITIVE DONOR AND CMV SERONEGATIVE RECIPIENT (D+/R-)) AND DOCUMENTATION THAT MEDICATION IS BEING USED FOR CMV PROPHYLAXIS AND DOCUMENTATION THAT THERAPY IS BEING INITIATED BETWEEN DAY 0 AND DAY 7 POST-TRANSPLANTATION.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A HEMATOLOGIST, ONCOLOGIST, INFECTIOUS DISEASE OR TRANSPLANT SPECIALIST

COVERAGE DURATION
HSCT: 100 DAYS, KIDNEY TRANSPLANT: 200 DAYS

OTHER CRITERIA
Documentation that medication is not being used in combination with pimozide, ergot alkaloids (ergotamine and dihydroergotamine), or pitavastatin or simvastatin (if co-administered with

cyclosporine).

PROCYSBI(GHP)

MEDICATION(S)
PROCYSBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF NEPHROPATHIC CYSTINOSIS

AGE RESTRICTION
MUST BE 1 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEPHROLOGIST, GENETICIST OR METABOLIC SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF ONE OF THE FOLLOWING: 1) INTOLERANCE TO CYSTAGON OR 2) DOCUMENTATION OF FAILURE TO ACHIEVE WBC CYSTINE LEVELS LESS THAN 1 NMOL HALF-CYSTINE/MG PROTEIN ON MAXIMALLY TOLERATED DOSE OF CYSTAGON.

PROLIA(GHP)

MEDICATION(S)
PROLIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Dx of postmenopausal osteoporosis with documentation of previous osteoporotic fracture or high risk of fracture defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors and/or FRAX calculation showing a 3% or more probability of hip fracture OR 20% or more probability of major osteoporosis related fracture OR failure on, intolerance to, or contraindication to one oral bisphosphonate. Dx of osteopenia in those at high risk of fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. Dx of male osteoporosis with documentation of previous osteoporotic fracture or high risk of fracture defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors and/or FRAX calculation showing a 3% or more probability of hip fracture OR 20% or more probability of major osteoporosis related fracture OR failure on, intolerance to, or contraindication to one oral bisphosphonate. Dx of osteopenia in those at high risk of fracture receiving androgen deprivation therapy for non-metastatic prostate cancer. Dx of glucocorticoid induced osteoporosis AND documentation of high risk of fracture defined as a DXA T-score of less than or equal to -2.0 at the lumbar spine, total hip, or femoral neck, supporting clinical factors and/or FRAX calculation showing a 3% or more probability of hip fracture OR 20% or more probability of major osteoporosis related fracture OR failure on, intolerance to, or contraindication to one oral bisphosphonate AND documentation of either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone AND documentation of expectation of remaining on glucocorticoid therapy for at least 6 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

For high risk of fracture receiving aromatase inhibitor or androgen deprivation therapy: failure on, intolerance to, or contraindication to one oral bisphosphonate

PROMACTA(GHP)

MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA (ITP) WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CORTICOSTEROIDS AND A PLATELET COUNT LESS THAN 30,000/MICROL WITH SYMPTOMATIC ITP WITH BLEEDING SYMPTOMS OR AN INCREASED RISK OF BLEEDING. DIAGNOSIS OF CHRONIC HEPATITIS C WITH THROMBOCYTOPENIA AND PLAN TO INITIATE OR CONTINUE INTERFERON-BASED THERAPY AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CORTICOSTEROIDS. DIAGNOSIS OF APLASTIC ANEMIA WITH A PLATELET COUNT LESS THAN 30,000/MICROL AND FAILURE ON ONE PRIOR IMMUNOSUPPRESSIVE THERAPY SUCH AS BUT NOT LIMITED TO CYCLOSPORINE OR FOR USE AS FIRST LINE TREATMENT IN COMBINATION WITH STANDARD IMMUNOSUPPRESSIVE THERAPY (SUCH AS BUT NOT LIMITED TO CYCLOSPORINE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
FOR ITP AND APLASTIC ANEMIA: PRESCRIBED BY HEMATOLOGIST OR ONCOLOGIST. FOR CHRONIC HEPATITIS C: PRESCRIBED BY GASTROENTEROLOGIST, HEMATOLOGIST, HEPATOLOGIST OR INFECTIOUS DISEASE PHYSICIAN.

COVERAGE DURATION
3 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA

For chronic ITP: documentation of a therapeutic failure on one previous treatment, including, but not limited to: corticosteroids, IVIG, Rhogam (if RhD-positive and spleen intact), Rituximab, or splenectomy, SUBSEQUENT APPROVAL AFTER 3 MONTHS WILL REQUIRE DOCUMENTATION OF MEDICAL NECESSITY SUCH AS A PLATELET COUNT NECESSARY TO REDUCE THE RISK FOR BLEEDING or A HEMATOLOGICAL RESPONSE.

PROMETHAZINE HRM(GHP)

MEDICATION(S)
PROMETHAZINE HCL 6.25 MG/5ML SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF ALLERGIC CONDITIONS (PRURITUS, URTICARIA, SEASONAL OR PERENNIAL ALLERGIES) WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DESLORATADINE AND LEVOCETIRIZINE. DIAGNOSIS OF NAUSEA AND VOMITING WILL REQUIRE DIAGNOSIS OF CANCER OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONDANSETRON AND PROCHLORPERAZINE. DIAGNOSIS OF MOTION SICKNESS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO MECLIZINE. FOR USE IN SEDATION INCLUDING PRODUCTION OF LIGHT SLEEP, REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ramelteon AND doxepin (generic Silenor).

PROVIGIL(GHP)

MEDICATION(S)
MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME, NARCOLEPSY OR SHIFT-WORK

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

PULMOZYME(GHP)

MEDICATION(S)
PULMOZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CYSTIC FIBROSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

PYRUKYND(GHP)

MEDICATION(S)
PYRUKYND, PYRUKYND TAPER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PYRUVATE KINASE DEFICIENCY (PKD).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A HEMOGLOBIN LEVEL LESS THAN OR EQUAL TO 10 G/DL. DOCUMENTATION OF AT LEAST 2 MUTANT ALLELES IN THE PKLR GENE, WITH AT LEAST 1 BEING A MISSENSE MUTATION AND DOCUMENTATION THAT MEMBER IS NOT HOMOZYGOUS FOR THE R479H MUTATION AND DOCUMENTATION THAT MEMBER REQUIRED RED BLOOD CELL (RBC) TRANSFUSIONS FOR HEMOLYTIC ANEMIA DUE TO PKD WITHIN THE LAST 12 MONTHS. REAUTHORIZATION WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF PROVIDER ASSESSED IMPROVEMENT IN HEMOGLOBIN FROM BASELINE OR REDUCTION IN TRANSFUSION BURDEN.

QINLOCK(GHP)

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of advanced gastrointestinal stromal tumor (GIST) AND documentation of prior treatment with three or more kinase inhibitors, including imatinib.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

QUDEXY(GHP)

MEDICATION(S)
TOPIRAMATE ER 100 MG CP24 SPRNK, TOPIRAMATE ER 150 MG CP24 SPRNK, TOPIRAMATE ER 200 MG CP24 SPRNK, TOPIRAMATE ER 25 MG CP24 SPRNK, TOPIRAMATE ER 50 MG CP24 SPRNK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES, PRIMARY GENERALIZED TONIC CLONIC SEIZURES, OR LENNOX GASTAUT SYNDROME or DIAGNOSIS OF MIGRAINE PROPHYLAXIS

AGE RESTRICTION
12 YEARS OR OLDER FOR MIGRAINE PROPHYLAXIS, 2 YEARS OF AGE OR OLDER FOR OTHER INDICATIONS

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTICONVULSANTS USED FOR THE REQUESTED DIAGNOSIS, ONE OF WHICH MUST BE IMMEDIATE-RELEASE TOPIRAMATE.

QUININE(GHP)

MEDICATION(S)
QUININE SULFATE 324 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR TREATMENT OF UNCOMPLICATED PLASMODIUM FALCIPARUM MALARIA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
7 DAYS

OTHER CRITERIA
N/A

QULIPTA(GHP)

MEDICATION(S)
QULIPTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MIGRAINE WITH OR WITHOUT AURA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF THE NUMBER OF BASELINE MIGRAINE OR HEADACHE DAYS PER MONTH AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: AIMOVIG, EMGALITY, NURTEC. DOCUMENTATION OR ATTESTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF BEING USED IN COMBINATION ATTESTATION OF THE FOLLOWING: THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND ATTESTATION OF A THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST. ATTESTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP RECEPTOR ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE.

REAUTHORIZATION WILL REQUIRE ATTESTATION OF CONTINUED OR SUSTAINED REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OR A DECREASE IN SEVERITY OR DURATION OF MIGRAINE AND EITHER ATTESTATION THAT THE MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF THE REQUEST IS FOR COMBINATION USE WITH BOTOX ATTESTATION OF THE FOLLOWING: PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND ATTESTATION OF A PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST AND ATTESTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP RECEPTOR ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE.

RADICAVA IV(GHP)

MEDICATION(S)
RADICAVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ALS (AMYOTROPHIC LATERAL SCLEROSIS) AND DOCUMENTATION OF BASELINE FUNCTIONAL STATUS (AS EVIDENCED BY A SCORING SYSTEM SUCH AS ALSFRS-R, OR BY PHYSICIAN DOCUMENTATION OF SUBJECTIVE REPORTS ON SPEECH, MOTOR FUNCTION, PULMONARY FUNCTION, ETC.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT RADICAVA IS BEING GIVEN IN COMBINATION WITH RILUZOLE, OR HAVE AN INTOLERANCE OR CONTRAINDICATION TO RILUZOLE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT MEMBER IS TOLERATING REGIMEN WITH DOCUMENTATION OF REGULAR PHYSICAN FOLLOW-UP.

RADICAVA(GHP)

MEDICATION(S)
RADICAVA ORS, RADICAVA ORS STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AMYOTROPIC LATERAL SCLEROSIS (ALS) AND DOCUMENTATION OF BASELINE FUNCTIONAL STATUS (AS EVIDENCED BY A SCORING SYSTEM SUCH AS ALSFRS-R, OR BY PHYSICIAN DOCUMENTATION OF SUBJECTIVE REPORTS ON SPEECH, MOTOR FUNCTION, PULMONARY FUNCTION, ETC.) AND DOCUMENTATION THAT RADICAVA IS BEING GIVEN IN COMBINATION WITH RILUZOLE OR INTOLERANCE TO OR CONTRAINDICATION TO RILUZOLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT MEMBER IS TOLERATING THERAPY WITH PRESCRIBED EDARAVONE REGIMEN AND DOCUMENTATION OF REGULAR PHYSICIAN FOLLOW-UP.

RAVICTI(GHP)

MEDICATION(S)
RAVICTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF UREA CYCLE DISORDER (UCD) AND DOCUMENTATION OF INCREASED BLOOD AMMONIA LEVELS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
METABOLIC DISORDER SPECIALIST OR GENETICIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE POWDER AND TABLETS. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT IN EITHER FASTING AMMONIA LEVELS, 24 HOUR AUC, OR NUMBER OF HYPERAMMONEMIC CRISES.

REBLOZYL(GHP)

MEDICATION(S)
REBLOZYL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF BETA THALASSEMIA AND DOCUMENTATION THAT PATIENT REQUIRES REGULAR RED BLOOD CELL (RBC) TRANSFUSIONS. DIAGNOSIS OF VERY LOW TO INTERMEDIATE RISK MYELODYSPLASTIC SYNDROMES WITH RING SIDEROBLASTS (MDS-RS) OR WITH MYELODYSPLASTIC/MYELOPROLIFERATIVE NEOPLASM WITH RING SIDEROBLASTS AND THROMBOCYTOSIS (MDS/MPN-RS-T) WITH ONE OF THE FOLLOWING: 1) DOCUMENTATION OF 15% OR MORE RING SIDEROBLASTS OR 2) 5% OR MORE RING SIDEROBLASTS AND AN SF3B1 MUTATION. DOCUMENTATION OF REQUIRING TWO OR MORE RED BLOOD CELL (RBC) UNITS OVER 8 WEEKS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF BASELINE NUMBER OF TRANSFUSIONS AND RED BLOOD CELL (RBC) UNITS REQUIRED FOR THE PREVIOUS 6 MONTHS. DOCUMENTATION THAT MEDICATION IS BEING DOSES CONSISTENT WITH FDA APPROVED LABELING. FOR ANEMIA ASSOCIATED WITH MDS: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR

CONTRAINDICATION TO AN ERYTHROPOIESIS STIMULATING AGENT. REAUTHORIZATION WILL REQUIRE AN INITIAL DECREASE IN RED BLOOD CELL (RBC) TRANSFUSION BURDEN, FOLLOWED BY A SUSTAINED REDUCTION OF RED BLOOD CELL (RBC) TRANSFUSION BURDEN AND THAT MEDICATION CONTINUES TO BE DOSED CONSISTENT WITH FDA APPROVED LABELING.

REBYOTA(GHP)

MEDICATION(S)
REBYOTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT REBYOTA WILL BE USED FOR THE PREVENTION OF RECURRENCE OF C. DIFFICILE INFECTIONS AND DOCUMENTATION OF A DIAGNOSIS OF RECURRENT C. DIFFICILE INFECTION BASED ON THE RESULTS OF AN APPROPRIATE LABORATORY STOOL TEST WITHIN 30 DAYS OF PRIOR AUTHORIZATION REQUEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST OR GASTROENTEROLOGIST

COVERAGE DURATION
1 MONTH

OTHER CRITERIA
DOCUMENTATION THAT AN APPROPRIATE STANDARD OF CARE ANTIBACTERIAL REGIMEN WAS USED FOR THE TREATMENT OF RECURRENT C. DIFFICILE INFECTION (SUCH AS BUT NOT LIMITED TO ORAL FIDAXOMICIN, ORAL VANCOMYCIN, ORAL METRONIDAZOLE) AND DOCUMENTATION THAT PRESCRIBED DOSE AND ADMINISTRATION IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED LITERATURE.

RECARBRIO(GHP)

MEDICATION(S)
RECARBRIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF COMPLICATED URINARY TRACT INFECTION CAUSED BY THE FOLLOWING SUCEPTIBLE GRAM NEGATIVE MICROORGANISMS: ENTEROBACTER CLOACAE, ESCHERICHIA COLI, KLEBSIELLA AEROGENES, KLEBSIELLA PENUMONIAE OR PSEUDOMONAS AERUGINOSA OR COMPLICATED INTRA-ABDOMINAL INFECTION CAUSED BY THE FOLLOWING SUSCEPTIBLE GRAM NEGATIVE MICROORGANISMS: BACTEROIDES CACCAE, BACTEROIDES FRAGILIS, BACTEROIDES OVATUS, BACTEROIDES STERCORIS, BACTEROIDES THETAIOTAOMICRON, BACTEROIDES UNIFORMIS, BACTEROIDES VULGATUS, CITROBACTER FREUNDII, ENTEROBACTER CLOACAE, ESCHERICHIA COLI, FUSOBACTERIUM NUCLEATUM, KLEBSIELLA AEROGENES, KLEBSIELLA OXYTOCA, KLEBSIELLA PNEUMONIAE, PARABACTEROIDES DISTASONIS OR PSEUDOMONAS AERUGINOSA OR DIAGNOSIS OF HOSPITAL ACQUIRED BACTERIAL PNEUMONIA OR VENTILATOR ASSOCIATED BACTERIAL PNEUMONIA CAUSED BY THE FOLLOWING SUSCEPTIBLE GRAM-NEGATIVE MICROORGANISMS: ACINETOBACTER CALCOACETICUS-BAUMANNII COMPLEX, ENTEROBACTER CLOACAE, ESCHERICHIA COLI, HAEMOPHILUS INFLUENZA, KLEBSIELLA AEROGENES, KLEBSIELLA OXYTOCA, KLEBSIELLA PNEUMONIAE, PSEUDOMONAS AERUGINOSA, AND SERRATIA MARCESCENS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION

2 WEEKS

OTHER CRITERIA

DOCUMENTATION OF A CULTURE AND SENSITIVITY SHOWING THE PATIENT'S INFECTION IS NOT SUSCEPTIBLE TO PREFERRED ALTERNATIVE ANTIBIOTICS TREATMENTS OR A DOCUMENTED HISTORY OF PREVIOUS INTOLERANCE TO OR CONTRAINDICATION TO TWO OTHER ANTIBIOTICS SHOWN TO BE SUSCEPTIBLE ON THE CULTURE AND SENSITIVITY. DOCUMENTATION OF A THERAPEUTIC FAILURE ON IMIPENEM-CILASTIN OR MEDICAL RATIONALE OF WHY IMIPENEM-CILASTIN CANNOT BE USED.

REGRANEX(GHP)

MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of lower extremity diabetic neuropathic ulcers (i.e., diabetic foot ulcer) that extend into the subcutaneous tissue or beyond and have an adequate blood supply.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

RELISTOR(GHP)

MEDICATION(S)
RELISTOR 12 MG/0.6ML SOLUTION, RELISTOR 8 MG/0.4ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL RECORD DOCUMENTATION OF OPIOID INDUCED CONSTIPATION IN THOSE WITH ADVANCED ILLNESS RECEIVING PALLIATIVE CARE AND CONCURRENT USE OF OPIOID THERAPY OR FOR OPIOID INDUCED CONSTIPATION WITH CHRONIC NONCANCER PAIN, INCLUDING PATIENTS WITH CHRONIC PAIN RELATED TO PRIOR CANCER AND ITS TREATMENT AND CONCURRENT USE OF OPIOID THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR OPIOID INDUCED CONSTIPATION WITH ADAVANCED ILLNESS RECEIVING PALLIATIVE CARE: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LACTULOSE AND POLYETHYLENE GLYCOL 3350. FOR OPIOID INDUCED CONSTIPATION WITH CHRONIC NONCANCER PAIN: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LACTULOSE or POLYETHYLENE GLYCOL 3350 AND AMITIZA

RELYVRIO(GHP)

MEDICATION(S)
RELYVRIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AMYOTROPHIC LATERAL SCLEROSIS (ALS).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE THAT MEMBER IS TOLERATING PRESCRIBED RELYVRIO REGIMEN AND DOCUMENTATION OF REGULAR PHYSICIAN FOLLOW-UP.

REPATHA(GHP)

MEDICATION(S)
REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD), INCUDING ACUTE CORONARY SYNDROMES (A HX OF MI OR UNSTABLE ANGINA), CORONARY OR OTHER ARTERIAL REVASCULARIZATION, STROKE TIA OR PAD PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN. PRIMARY HYPERLIPIDEMIA. HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) WITH ONE OF THE FOLLOWING: GENETIC TESTING TO CONFIRM MUTATION IN THE LDL RECEPTOR, PCSK9, OR APOB GENE OR DX OF DEFINITE HEFH (SCORE GREATER THAN 8) ON THE DUTCH LIPID CLINIC NETWORK DIAGNOSTIC CRITERIA. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH), WITH ONE OF THE FOLLOWING: (1) GENETIC TESTING TO CONFIRM DX SHOWING A MUTATION IN THE LDL RECEPTOR, PCSK9 GENE, APOB GENE OR LDL PROTEIN RECEPTOR ADAPTOR 1 (LDLRAP1) GENE OR (2) DX MADE BASED ON A HISTORY OF UNTREATED LOW-DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) GREATER THAN 500 MG/DL AND EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HEFH IN BOTH PARENTS. DOCUMENTATION OF A LDL DRAWN WITHIN 3 MONTHS OF THE START OF PCSK9 THERAPY SHOWING AN LDL GREATER THAN 130 IN PEDIATRIC PATIENTS 10 YEARS OF AGE OR OLDER IF USING FOR PRIMARY PREVENTION, AN LDL GREATER THAN 100 IN ADULT PATIENTS USING FOR PRIMARY PREVENTION OR AN LDL GREATER THAN 70 IF USING FOR SECONDARY PREVENTION. FOR STATIN TOLERANT PATIENTS, DX OF AN INABILITY TO ACHIEVE AND MAINTAIN LDL GOAL WITH ONE OF THE FOLLOWING (1) MAX TOLERATED DOSE OF A HIGH INTENSITY STATIN (ATORVASTATIN 40 MG OR HIGHER OR ROSUVASTATIN 20 MG OR HIGHER) OR (2) A MAX TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT HAS HAD A PREVIOUS TRIAL OF EITHER ATORVASTATIN OR ROSUVASTATIN, WITH PRESCRIBER'S DOCUMENTATION

REGARDING LENGTH OF PREVIOUS TRIALS OF STATINS. PATIENT MUST INTEND TO CONTINUE ON MAXIMAL STATIN THERAPY ONCE REPATHA STARTED. FOR STATIN INTOLERANT PATIENTS DOCUMENTATION OF REASON FOR STATIN INTOLERANCE AND IN THOSE WITH HOFH, DX OF AN INABILITY TO ACHIEVE AND MAINTAIN LDL GOAL ON AT LEAST 12 WEEKS ON MAXIMAL LIPID LOWERING THERAPY

AGE RESTRICTION

FOR ASCVD: MUST BE 18 YEARS OF AGE OR OLDER. FOR HOFH or HEFH: MUST BE 10 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

DX THAT REPATHA IS NOT BEING USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR. IF REQUESTING SYRINGE OR SURECLICK DOSING OF 420 MG: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO USE OF REPATHA PUSHTRONEX. IF REQUESTING 420 MG EVERY 2 WEEKS: DOCUMENTATION OF A DIAGNOSIS OF HOFH AND ONE OF THE FOLLOWING: DOCUMENTATION THAT THE MEMBER HAS BEEN ON 420 MG ONCE MONTHLY FOR 12 WEEKS AND A CLINICALLY MEANINGFUL RESPONSE HAS NOT BEEN ACHIEVED OR DOCUMENTATION THAT THE MEMBER IS ON LIPID APHERESIS EVERY 2 WEEKS. THERAPEUTIC FAILURE IS DEFINED AS AN INABILITY TO REACH TARGET LDL GOALS (LESS THAN 130 FOR PEDIATRIC PATIENTS, LESS THAN 100 MG/DL FOR ADULT PATIENTS WITH HEFH OR HOFH IN PRIMARY PREVENTION OR LESS THAN 70 MG/DL FOR ASCVD OR FOR HEFH OR HOFH USING AS SECONDARY PREVENTION) DESPITE AT LEAST A 3 MONTH TRIAL. INTOLERANCE TO STATINS IS DEFINED AS INCREASED LFTS, INTOLERABLE MYALGIA (MUSCLE SYMPTOMS WITHOUT CREATININE KINASE (CK) ELEVATIONS) OR MYOPATHY (MUSCLE SYMPTOMS WITH CK ELEVATIONS), OR MYOSITIS (ELEVATIONS IN CK WITHOUT MUSCLE SYMPTOMS), WHICH PERSIST AFTER RETRIAL WITH A DIFFERENT DOSE OR DIFFERENT DOSING STRATEGY (EVERY OTHER DAY) OF ALTERNATIVE MODERATE- OR HIGH-INTENSITY STATIN. CONTRAINDICATIONS TO STATINS ARE DEFINED AS ACTIVE LIVER DISEASE, PREVIOUS HISTORY OF RHABDOMYOLYSIS, OR HYPERSENSITIVITY. RENEWAL CRITERIA: DOCUMENTATION OR PRESCRIBER ATTESTATION OF CLINICALLY SIGNIFICANT RESPONSE TO TREATMENT AND DOCUMENTATION OF NO SIGNIFICANT ADVERSE EVENTS RELATED TO THERAPY AND DOCUMENTATION OF STILL

TAKING STATIN (IF STATIN TOLERANT) AND DOCUMENTATION THAT REPATHA CONTINUES TO NOT BE USED IN COMBINATION WITH ANOTHER PCSK9 INHIBITOR, AND IF REQUESTING SYRINGE OR SURECLICK DOSING OF 420 MG: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO USE OF REPATHA PUSHTRONEX. IF REQUESTING 420 MG EVERY 2 WEEKS: DOCUMENTATION OF A DIAGNOSIS OF HOFH AND ONE OF THE FOLLOWING: DOCUMENTATION OF THERAPEUTIC FAILURE ON 420 MG ONCE MONTHLY FOR 12 WEEKS OR DOCUMENTATION THAT THE MEMBER IS ON LIPID APHERESIS EVERY 2 WEEKS.

RETEVMO(GHP)

MEDICATION(S)
RETEVMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of RET-fusion positive non-small cell lung cancer (NSCLC). Documentation of advanced metastatic RET-mutant medullary thyroid cancer (MTC) AND documentation that systemic therapy is required. Documentation of advanced or metastatic RET-fusion positive thyroid cancer AND documentation that systemic therapy is required AND documentation that patient radioactive-iodine refractory when radioactive iodine is appropriate. Documentation of a locally advanced or metastatic solid tumor with a RET gene fusion AND either documentation of progression on or following prior systemic therapy OR that member has no satisfactory alternative treatment options.

AGE RESTRICTION
NSCLC AND SOLID TUMORS: 18 YEARS OR OLDER. THYROID CA: 12 YEARS OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

REVATIO(GHP)

MEDICATION(S)
SILDENAFIL CITRATE 10 MG/12.5ML SOLUTION, SILDENAFIL CITRATE 10 MG/ML RECON SUSP, SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
CONCOMITANT USE OF ORGANIC NITRATES

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF FUNCTIONAL CLASS 2, 3, OR 4 PULMONARY ARTERIAL HYPERTENSION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

REVCOVI(GHP)

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF ADENOSINE DEAMINASE DEFICIENCY-ASSOCIATED SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID) CONFIRMED BY EITHER A VERY LOW PRESENCE OR ABSENCE OF ADA (ADENOSINE DEAMINASE) ACTIVITY IN RED BLOOD CELLS OR OTHER SAMPLES AND AN INCREASE IN ADENOSINE, DEOXYADENOSINE, AND DEOXYADENOSINE TRIPHOSPHATE (DATP) LEVELS IN RED BLOOD CELLS, PLASMA, OR URINE OR BIALLELIC MUTATIONS IN THE ADA1 GENE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH AN IMMUNOLOGIST, GENETICIST, OR A PHYSICIAN WHO SPECIALIZES IN INHERITED METABOLIC DISORDERS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT DOSING IS CONSISTENT WITH FDA APPROVED LABELING. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED OR SUSTAINED IMPROVEMENT SUCH AS BUT NOT LIMITED TO TROUGH PLASMA ADA AND DAXP LEVELS WHILE ON THERAPY AND DOCUMENTATION OF PLANNED HEMATOPOIETIC CELL TRANSPLANTATION OR GENE THERAPY OR DOCUMENTATION OF NOT BEING A SUITABLE

CANDIDATE FOR HEMATOPOIETIC CELL TRANSPLANTATION AND GENE THERAPY AT THE TIME OF THE REQUEST.

REVLIMID(GHP)

MEDICATION(S)
LENALIDOMIDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF MULTIPLE MYELOMA. DX OF MYELODYSPLASTIC SYNDROMES (MDS) EITHER WITH A DELETION 5Q CYTOGENETIC ABNORMALITY WITH OR WITHOUT ADDITIONAL CYTOGENETIC ABNORMALITIES OR WITH NO DELETION 5Q CYTOGENETIC ABNORMALITY. DX OF RELAPSED, REFRACTORY, OR PROGRESSIVE MANTLE CELL LYMPHOMA WITH THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE PRIOR THERAPY INCLUDING BUT NOT LIMITED TO HYPERCVAD, NORDIC REGIMEN, CALGB REGIMEN, RCHOP/RICE, RCHOP/RDHAP, BENDAMUSTINE PLUS RITUXIMAB, CHOP PLUS RITUXIMAB, CLADRIBINE PLUS RITUXIMAB, CVP PLUS RITUXIMAB, EPOCH PLUS RITUXIMAB. DX OF FOLLICULAR LYMPHOMA OR MARGINAL ZONE LYMPHOMA, USED IN COMBINATION WITH RITUXIMAB, FOLLOWING THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO AT LEAST 1 PRIOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR MDS WITH NO DELETION 5Q CYTOGENETIC ABNORMALITY: DOCUMENTATION OF

INITIAL USE IN LOWER RISK PATIENT WITH SYMPTOMATIC ANEMIA AND SERUM ERYTHROPOIETIN LEVELS GREATER THAN 500 MU/ML AND A LOW PROBABILITY (DEFINED AS MEMBERS WHO LACK ANY OF THE FOLLOWING FEATURES: AGE LESS THAN OR EQUAL TO 60, OR THOSE WITH HYPOCELLULAR MARROW, HLA-DR 15 OR PHN CLONE POSITIVITY) OF RESPONSE TO IMMUNOSUPPRESSIVE THERAPY OR DOCUMENTATION OF LOWER RISK PATIENT WITH SYMPTOMATIC ANEMIA AND NO RESPONSE TO INITIAL TREATMENT WITH EPOETIN ALFA OR DARBOPOETIN ALFA, HYPOMETHYLATING AGENTS, OR IMMUNOSUPPRESSIVE THERAPY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

REXULTI(GHP)

MEDICATION(S)
REXULTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA. ADJUNCTIVE TREATMENT FOR MAJOR DEPRESSIVE DISORDER (MDD). DIAGNOSIS OF AGITATION ASSOCIATED WITH DEMENTIA DUE TO ALZHEIMER'S DISEASE AND DOCUMENTATION THAT REXULTI WILL NOT BE TAKEN ON AN AS-NEEDED (PRN) BASIS.

AGE RESTRICTION
Schizophrenia: 13 years of age or older. MDD:18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR MDD: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST A 4 WEEK TRIAL OF ADD ON ANTIDEPRESSANT THERAPY WITH ARIPIPRAZOLE. FOR SCHIZOPHRENIA, DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY MEDICATIONS ONE OF WHICH MUST BE ARIPIPRAZOLE (ARIPIPRAZOLE, OLANZAPINE, RISPERIDONE, QUETIAPINE IR, OR ZIPRASIDONE). FOR AGITATION ASSC. W/ DEMENTIA: DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTIPSYCHOTICS USED FOR THE TREATMENT OF AGITATION ASSOCIATED WITH DEMENTIA (SUCH AS BUT

NOT LIMITED TO QUETIAPINE, RISPERIDONE, OLANZAPINE, ETC.).

REZLIDHIA(GHP)

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY ACUTE MYELOID LEUKEMIA AND DOCUMENTATION OF A SUSCEPTIBLE ISOCITRATE DEHYDROGENASE-1 (IDH1) MUTATION AS DETECTED BY AN FDA-APPROVED TEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

REZUROCK(GHP)

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF STEROID REFRACTORY GRAFT-VERSUS-HOST DISEASE (GVHD) AND DOCUMENTATION OF THERAPEUTIC FAILURE OF TWO OR MORE PRIOR LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST, OR TRANSPLANT SPECIALIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
IF REQUEST IS FOR 200 MG TWICE DAILY DOSING, DOCUMENTATION OF ONE OF THE FOLLOWING:1) DOCUMENTATION THAT MEMBER IS CURRENTLY RECEIVING A STRONG CYP3A4 INDUCER OR 2) IF CONCURRENTLY TAKING WITH A PROTON PUMP INHIBITOR (PPI), MEDICAL RECORD DOCUMENTATION THAT TREATMENT WITH A PPI IS MEDICALLY NECESSARY AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A H2-BLOCKER. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUE DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND IF REQUEST IS FOR 200 MG TWICE DAILY DOSING, DOCUMENTATION OF ONE OF THE FOLLOWING:1) DOCUMENTATION THAT MEMBER IS CURRENTLY RECEIVING A

STRONG CYP3A4 INDUCER OR 2) IF CONCURRENTLY TAKING WITH A PROTON PUMP INHIBITOR (PPI), MEDICAL RECORD DOCUMENTATION THAT TREATMENT WITH A PPI IS MEDICALLY NECESSARY AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A H2-BLOCKER.

REZZAYO(GHP)

MEDICATION(S)
REZZAYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF NON-NEUTROPENIC PATIENT WITH A DIAGNOSIS OF CANDIDEMIA OR INVASIVE CANDIDIASIS (OTHER THAN ENDOCARDITIS, OSTEOMYELITIS, OR MENINGITIS) AND DOCUMENTATION THAT MEMBER HAS LIMITED OR NO ALTERNATIVE TREATMENT OPTIONS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
4 WEEKS (ONE COURSE OF THERAPY)

OTHER CRITERIA
N/A

RINVOQ(GHP)

MEDICATION(S)
RINVOQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA. DIAGNOSIS OF ACTIVE PSORIATIC ARTHRITIS AND ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS. DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS. DIAGNOSIS OF MODERATE TO SEVERE ULCERATIVE COLITIS. DIAGNOSIS OF ANKYLOSING SPONDYLITIS. DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS WITH DOCUMENTATION OF EITHER C-REACTIVE PROTEIN (CRP) LEVEL ABOVE THE UPPER LIMIT OF NORMAL OR SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CROHNS DISEASE (CD).

AGE RESTRICTION
FOR AD: MUST BE 12 YEARS OF AGE OR OLDER, ALL OTHERS: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST, IMMUNOLOGIST, OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH ANOTHER

JAK INHIBITOR, BIOLOGIC IMMUNOMODULATOR, OR OTHER IMMUNOSUPPRESSANT. FOR RA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA OR ENBREL. FOR PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA OR ENBREL. FOR AD: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DAILY AT LEAST MEDIUM POTENCY TOPICAL CORTICOSTEROIDS OR CALCINEURIN INHIBITOR (I.E. TACROLIMUS) IF TOPICAL CORTICOSTEROIDS ARE NOT ADVISABLE AND THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DUPIXENT. FOR UC: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA. FOR AS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ENBREL OR HUMIRA. FOR NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF CIMZIA. FOR CD: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA. REAUTHORIZATION WILL REQUIRE DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION

RITUXAN HYCELA(GHP)

MEDICATION(S)
RITUXAN HYCELA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) GIVEN IN COMBINATION WITH FLUDARABINE AND CYCLOPHOSPHAMIDE AND DOCUMENTATION OF TOLERATING A MINIMUM OF ONE CYCLE OF INTRAVENOUS RITUXIMAB. DIAGNOSIS OF DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) AND DOCUMENTATION OF NO PRIOR TREATMENT FOR DLBCL AND DOCUMENTATION OF BEING GIVEN IN COMBINATION WITH CYCLOPHOSPHAMIDE, DOXORUBICIN, VINCRISTINE AND PREDNISONE (CHOP) OR OTHER ANTHRACYCLINE-BASED CHEMOTHERAPY REGIMEN AND DOCUMENTATION OF TOLERATING A MINIMUM OF ONE CYCLE OF INTRAVENOUS RITUXIMAB. DIAGNOSIS OF FOLLICULAR LYMPHOMA (FL) AND DOCUMENTATION OF TOLERATING A MINIMUM OF ONE CYCLE OF INTRAVENOUS RITUXIMAB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REQUESTS EXCEEDING THE

MAXIMUM FDA-APPROVED TREATMENT DURATION WILL REQUIRE DOCUMENTATION OF PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATION THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

RITUXAN(GHP)

MEDICATION(S)
RIABNI, RUXIENCE, TRUXIMA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA AND DOCUMENTATION THAT METHOTREXATE WILL BE CONTINUED DURING RITUXIMAB THERAPY. DX OF ACUTE LYMPHOBLASTIC LEUKEMIA, HAIRY CELL LEUKEMIA OR CHRONIC LYMPHOCYTIC LEUKEMIA. DX OF MICROSCOPIC POLYARTERITIS NODOSA USED IN COMBO WITH GLUCOCORTICOIDS. DX OF DIFFUSE NON-HODGKINS LYMPHOMA. DX OF HODGKIN LYMPHOMA. DX OF GRANULOMATOSIS WITH POLYANGIITIS (GPA) (WEGENER'S GRANULOMATOSIS OR MICROSCOPIC POLYANGIITIS (MPA) USED IN COMBINATION WITH GLUCOCORTICOIDS. DX OF CHRONIC ITP AND PLATELET COUNT OF LESS THAN 30,000/MICROL WITH ACTIVE BLEEDING OR PLATELET COUNT OF LESS THAN 20,000/MICROL WITH INCREASED RISK OF BLEEDING AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CORTICOSTEROIDS AND IVIG. DX OF MULTIPLE SCLEROSIS. DX OF MODERATE TO SEVERE PEMPHIGUS VULGARIS (PV).

AGE RESTRICTION
FOR RA AND PV: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
FOR RA: RHEUMATOLOGIST, FOR PV: DERMATOLOGIST

COVERAGE DURATION
FOR RA AND ITP: 3 MONTHS. FOR CLL, NHL AND MS: INDEFINITE, ALL OTHER DIAGNOSES: 12 MONTHS

OTHER CRITERIA

FOR RA, MPN, GPA, MPA, ITP, and PV: DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO (2) PREFERRED BIOLOGIC AGENTS INDICATED FOR RHEUMATOID ARTHRITIS (HUMIRA*, ENBREL*, RINVOQ*, XELJANZ*). ONE COURSE OF THERAPY IS DEFINED AS TWO INFUSIONS GIVEN ON DAY 1 AND ANOTHER ON DAY 15. ADDITIONAL COURSES MAY BE CONSIDERED MEDICALLY NECESSARY IF AT LEAST 6 MONTHS HAS ELAPSED SINCE THE PREVIOUS TREATMENT COURSE AND DOCUMENTATION OF IMPROVEMENT. FOR PV: DOCUMENTATION OF A CONTRAINDICATION TO, INTOLERANCE OR THERAPEUTIC FAILURE ON CORTICOSTEROIDS AND A 12-WEEK TRIAL OF AT LEAST ONE NONSTEROIDAL IMMUNOMODULATORY MEDICATION (I.E. AZATHIOPRINE, CYCLOPHOSPHAMIDE OR MYCOPHENOLATE)

ROLVEDON(GHP)

MEDICATION(S)
ROLVEDON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE, BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY

TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CrcL LESS THAN 50 ML/MIN).

ROZLYTREK(GHP)

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND one of the following 1)documentation of progression following treatment or 2) documentation of no satisfactory alternative treatments. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive.

AGE RESTRICTION
For NTRK positive tumors: 1 month of age or older. For NSCLC: 18 yrs or older

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

RUBRACA(GHP)

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum based chemotherapy. Diagnosis of a deleterious BRCA mutation (germline and/or somatic)-associated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer AND medication is being used for maintenance treatment after a complete or partial response to platinum based chemotherapy. Diagnosis of deleterious BRCA mutation (germline or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) with documentation of prior treatment with androgen receptor-directed therapy and a taxane based chemotherapy.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For mCRPC: documentation that a gonadotropin-releasing hormone (GnRH) analog will be used concurrently OR documentation of bilateral orchiectomy. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

RUXOLITINIB(GHP)

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS, INCLUDING PRIMARY MYELOFIBROSIS, POST-POLYCYTHEMIA VERA MYELOFIBROSIS OR POST-ESSENTIAL THROMBOCYTHEMIA MYELOFIBROSIS AND PLATELET COUNT GREATER THAN OR EQUAL TO 50 X 10(9)/L AND SPLENOMEGALY AND BASELINE TOTAL SYMPTOM SCORE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF). DIAGNOSIS OF POLYCYTHEMIA VERA REQUIRING THE PRESENCE OF SPLENOMEGALY, AND MEMBER REQUIRES PHLEBOTOMY. DIAGNOSIS OF (1) STEROID REFRACTORY ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD) OR (2) DIAGNOSIS OF CHRNOIC GRAFT-VERSUS-HOST DISEASE WITH DOCUMENTATION OF THERAPEUTIC FAILURE OF ONE OR TWO PRIOR LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST, HEMATOLOGIST OR TRANSPLANT SPECIALIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH ANOTHER JANUS KINASE INHIBITOR (I.E. FEDRATINIB). FOR MYELOFIBROSIS: CONTINUED COVERAGE

EVERY 6 MONTHS WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF PLATELET COUNT GREATER THAN OR EQUAL TO 50 X 10(9)/L IF BASELINE COUNT WAS GREATER THAN 100 X 10(9)/L OR GREATER THAN 25 X 10(9)/L IF BASELINE COUNT WAS BETWEEN 50 AND 100 X 10(9)/L, AND DOCUMENTATION OF RESPONSE TO THERAPY SUCH AS A REDUCTION FROM PRETREATMENT BASELINE SPLEEN VOLUME OR A REDUCTION IN THE TOTAL SYMPTOM SCORE FROM BASELINE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF). FOR POLYCYTHEMIA VERA DOCUMENTATION OF OF AN INADEQUATE RESPONSE OR INTOLERANCE TO EITHER HYDROXYUREA OR INTERFERON THERAPY OR DOCUMENTATION OF POST POLYCYTHEMIA VERA MYELOFIBROSIS WITH HYDROXYUREA REFRACTORY SYMPTOMATIC SPLENOMEGALY. REAUTHORIZATION FOR GRAFT VERSUS HOST DISEASE AND POLYCYTHEMIA VERA WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

RYALTRIS(GHP)

MEDICATION(S)
RYALTRIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ALLERGIC RHINITIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BOTH OF THE FOLLOWING: (1) INTRANASAL OLOPATADINE IN COMBINATION WITH INTRANASAL MOMETASONE AND (2) INTRANASAL AZELASTINE-FLUTICASONE.

RYBREVANT(GHP)

MEDICATION(S)
RYBREVANT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AND DOCUMENTATION OF EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATATIONS AS DETERMINED BY AN FDA APPROVED TEST AND DOCUMENTATION OF ONE OF THE FOLLOWING (1) USE AS SINGLE AGENT THERAPY WITH DISEASE PROGRESSION ON OR FOLLOWING PRIOR TREATMENT WITH A PLATINUM BASED THERAPY OR (2) IN COMBINATION WITH CARBOPLATIN AND PEMETREXED WHEN BEING USED AS FIRST LINE TREATMENT.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

RYDAPT(GHP)

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of acute myeloid leukemia (AML) that is FLT3 mutation positive as detected by a Food and Drug Administration (FDA)-approved test used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation OR documentation of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS RENEWAL

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

RYLAZE(GHP)

MEDICATION(S)
ERWINASE, ERWINAZE, RYLAZE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE AS A COMPONENT OF A MULTI-AGENT CHEMOTHERAPEUTIC REGIMEN IN PATIENTS WITH A DIAGNOSIS OF ACTUE LYMPHOBLASTIC LEUKEMIA (ALL) OR LYMPHOBLASTIC LYMPHOMA (LBL)

AGE RESTRICTION
1 MONTH OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A HYPERSESITIVITY TO E.COLI-DERIVED ASPARAGINASE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

SABRIL(GHP)

MEDICATION(S)
VIGABATRIN, VIGADRONE 500 MG PACKET, VIGPODER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF REFRACTORY COMPLEX PARTIAL SEIZURES. DX OF INFANTILE SPASMS.

AGE RESTRICTION
INFANTILE SPASMS - 1 MONTH TO 2 YEARS OF AGE

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR REFRACTORY COMPLEX PARTIAL SEIZURES MUST BE ON CONCOMMITANT THERAPY WITH ANOTHER SEIZURE CONTROL MEDICATION

SANTYL(GHP)

MEDICATION(S)
SANTYL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of use for debriding chronic dermal ulders or severely burned areas.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatologist OR burn or wound care specialist

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT THE PRESCRIBED DOSE IS MEDICALLY NECESSARY BASED ON THE WOUND LENGTH, WOUND WIDTH, AND INTENDED DURATION OF THERAPY.
REAUTHORIZATION WILL REQUIRE (1)DOCUMENTATION THAT THE MEMBER CONTINUES TO BE EVALUATED BY A BURN, WOUND CARE OR OTHER SPECIALIST WITH EXPERIENCE IN THE MANAGMENT OF SEVERE WOUNDS AND (2) DOCUMENTATION THAT THE PRESCRIBED DOSE IS MEDICALLY NECESSARY BASED ON THE WOUND LENGTH, WOUND WIDTH, AND INTENDED DURATION OF THERAPY.

SAPHNELO(GHP)

MEDICATION(S)
SAPHNELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF MODERATE TO SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEMBER DOES NOT HAVE ACTIVE LUPUS NEPHRITIS OR SEVERE ACTIVE CENTRAL NERVOUS SYSTEM LUPUS. DOCUMENTATION OF CURRENTLY RECEIVING A STABLE TREATMENT REGIMEN WITH CORTICOSTEROIDS, ANTIMALARIALS, OR IMMUNOSUPPRESSANTS. DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH OTHER BIOLOGIC AGENTS, INCLUDING B-CELL TARGETED THERAPIES. REAUTHORIZATION WILL REQUIRE PROVIDER ASSESSMENT OF CLINICAL BENEFIT OF ONE OF THE FOLLOWING: IMPROVEMENT IN FUNCTIONAL IMPAIRMENT, DECREASE IN NUMBER OF EXACERBATIONS SINCE STARTING MEDICATION, OR DECREASE IN THE DAILY REQUIRED DOSE OF ORAL CORTICOSTEROIDS.

SAPHRIS(GHP)

MEDICATION(S)
ASENAPINE MALEATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF BIPOLAR DISORDER OR SCHIZOPHRENIA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF TRIAL ON TWO FORMULARY ALTERNATIVES (aripiprazole, ziprasidone, risperidone, quetiapine, olanzapine).

SARCLISA(GHP)

MEDICATION(S)
SARCLISA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ONE OF THE FOLLOWING (1) DIAGNOSIS OF MULTIPLE MYELOMA AND DOCUMENTATION OF USE IN COMBINATION WITH POMALIDOMIDE AND DEXAMETHASONE AND DOCUMENTATION OF PRIOR TREATMENT WITH AT LEAST TWO THERAPIES WHICH INCLUDED LENALIDOMIDE AND A PROTEASOME INHIBITOR (INCLUDING BUT NOT LIMITED TO VELCADE, KYPROLIS OR NINLARO) OR (2) DIAGNOSIS OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA AND DOCUMENTATION OF USE IN COMBINATION WITH CARFILZOMIB AND DEXAMETHASONE AND DOCUMENTATION OF PRIOR TREATMENT WITH ONE TO THREE LINES OF THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

SCEMBLIX(GHP)

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (PH+ CML) IN CHRONIC PHASE (CP) AND ONE OF THE FOLLOWING: 1) DOCUMENTATION OF PREVIOUS TREATMENT WITH TWO OR MORE TYROSINE KINASE INHIBITORS (TKIS) OR 2) DOCUMENTATION OF A T315I CELL MUTATION.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
IF THE REQUESTED DOSE IS 200 MG TWICE DAILY: DOCUMENTATION OF A T315I CELL MUTATION. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

SECUADO(GHP)

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of schizophrenia

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Medical record documentation of a therapeutic failure on, intolerance to or contraindication to asenapine (Saphris) sublinqual tablets and one other formulary alternative (aripiprazole, ziprasidone, risperidone, quetiapine, olanzapine)

SEROSTIM(GHP)

MEDICATION(S)
SEROSTIM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR THE TREATMENT OF HIV PATIENTS WITH WASTING OR CACHEXIA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

SIGNIFOR LAR(GHP)

MEDICATION(S)
SIGNIFOR LAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF ACROMEGALY AND DOCUMENTATION OF AN INADEQUATE RESPONSE TO OR THE INABILITY TO BE TREATED WITH SURGERY OR RADIOTHERAPY. DOCUMENTATION OF A DIAGNOSIS OF CUSHING'S DISEASE AND DOCUMENTATION THAT PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FOR ACROMEGALY: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO OCTREOTIDE AND SOMATULINE DEPOT. REAUTHORIZATION REQUIRES IMPROVEMENT OF IGF-1 OR GH LEVELS. FOR CUSHING'S DISEASE: FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO KETOCONAZOLE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT IN URINARY FREE CORTISOL LEVELS COMPARED TO BASELINE

SIGNIFOR(GHP)

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF CUSHING'S DISEASE AND DOCUMENTATION THAT PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO KETOCONAZOLE. REAUTHORIZATION REQUIRES DOCUMENTATION OF IMPROVEMENT IN URINARY FREE CORTISOL LEVELS COMPARED TO BASELINE

SIKLOS(GHP)

MEDICATION(S)
SIKLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of sickle cell anemia.

AGE RESTRICTION
2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a hematologist

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of generic hydroxyurea

SIMPONI(GHP)

MEDICATION(S)
SIMPONI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSICIATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS AND BEING USED IN CONJUNCTION WITH METHOTREXATE. DX OF ACTIVE PSORIATIC ARTHRITIS AND DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS AND PRESCRIPTION IS NOT WRITTEN FOR SIMPONI ARIA (IV FORMULATION). DX OF ANKYLOSING SPONDYLITIS AND PRESCRIPTION IS NOT WRITTEN FOR SIMPONI ARIA (IV FORMULATION). DX OF MODERATE TO SEVERE ULCERATIVE COLITIS AND PRESCRIPTION IS NOT WRITTEN FOR SIMPONI ARIA (IV FORMULATION).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, GASTROENTEROLOGIST, DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR RA (ENBREL, HUMIRA, RINVOQ, XELJANZ). FOR ANKYLOSING SPONDYLITIS: FAILURE

ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR AS (COSENTYX, ENBREL, HUMIRA, XELJANZ, RINVOQ). FOR PSORIATIC ARTHRITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PSA (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA, RINVOQ, XELJANZ). FOR ULCERATIVE COLITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

SIRTURO(GHP)

MEDICATION(S)
SIRTURO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RESISTANCE TO ISONIAZID AND RIFAMPIN AND DOCUMENTATION THAT AN EFFECTIVE TREATMENT REGIMEN CANNOT BE ATTAINED WITH OTHER AVAILABLE TREATMENT OPTIONS AND DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH AT LEAST THREE OTHER DRUGS TO WHICH THE PATIENT'S MULTI DRUG RESISTANT TB ISOLATE HAS BEEN SHOWN TO BE SUSCEPTIBLE IN VITRO

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
24 WEEKS

OTHER CRITERIA
IF IN VITRO TESTING RESULTS ARE UNAVAILABLE, DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH AT LEAST 4 OTHER DRUGS TO WHICH THE PATIENTS MDR-TB ISOLATE IS LIKELY TO BE SUSCEPTIBLE

SIVEXTRO(GHP)

MEDICATION(S)
SIVEXTRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTION (INCLUDING CELLULITIS/ERYSIPELAS, WOUND INFECTION, AND MAJOR CUTANEOUS ABSCESS) CAUSED BY STAPHYLOCOCCUS AUREUS, STREPTOCOCCUS PYOGENES, STREPTOCOCCUS AGALACTIAE, STREPTOCOCCUS ANGINOSUS, STREPTOCOCCUS INTERMEDIUS, STREPTOCOCCUS CONSTELLATUS, OR ENTEROCOCCUS FAECALIS

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
DIAGNOSED AND DOCUMENTED WITH INFECTIOUS DISEASE CONSULTATION

COVERAGE DURATION
ONE-TIME COURSE OF THERAPY OF 6 DAYS

OTHER CRITERIA
DOCUMENTATION OF A CULTURE AND SENSITIVITY SHOWING THE PATIENT'S INFECTION IS NOT SUSCEPTIBLE TO ALTERNATIVE ANTIBIOTICS TREATMENTS OR A DOCUMENTED HISTORY OF PREVIOUS INTOLERANCE TO OR CONTRAINDICATION TO TWO OTHER ANTIBIOTICS SHOWN TO BE SUSCEPTIBLE ON THE CULTURE AND SENSITIVITY.

SKYCLARYS(GHP)

MEDICATION(S)
SKYCLARYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FRIEDRICH'S ATAXIA AND DOCUMENTATION OF GENETIC TESTING CONFIRMING FRATAXIN (FXN) GENE MUTATION AND DOCUMENTATION OF BASELINE MODIFIED FRIEDRICH'S ATAXIA RATING SCALE (mFARS) SCORE.

AGE RESTRICTION
16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT MEMBER IS RESPONDING POSITIVELY TO THERAPY AS EVIDENCED BY SLOWED DISEASE PROGRESSION OR DOCUMENTATION OF A POSITIVE CLINICAL RESPONSE (I.E., THROUGH MODIFIED FUNCTIONAL ASSESSMENT RATING SCALE).

SKYRIZI(GHP)

MEDICATION(S)
SKYRIZI, SKYRIZI (150 MG DOSE), SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR DISEASE AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. DIAGNOSIS OF ACTIVE PSORIATIC ARTHRITIS WITH A HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS. DX OF PERIPHERAL PSA OR AXIAL PSA. DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
DERMATOLOGIST, RHEUMATOLOGIST, OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO MTX OR PHOTOTHERAPY. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR

CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO FORMULARY NSAIDS. FOR CD: DOCUMENTATION OF MODERATE OR HIGH-RISK PATIENT OR A DX OF CROHNS DISEASE WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE, AZATHIOPRINE, CORTICOSTEROIDS OR METHOTREXATE OR DIAGNOSIS OF CROHN'S WITH ACTIVE DRAINING FISTULAS. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

SLEEPERS HRM(GHP)

MEDICATION(S)
ESZOPICLONE 1 MG TAB, ESZOPICLONE 2 MG TAB, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TAB, ZOLPIDEM TARTRATE 5 MG TAB, ZOLPIDEM TARTRATE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DOCUMENTATION OF FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO RAMELTEON (GENERIC ROZEREM) AND DOXEPIN (GENERIC SILENOR).

SOGROYA(GHP)

MEDICATION(S)
SOGROYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF GROWTH FAILURE DUE TO INADEQUATE ENDOGENOUS GROWTH HORMONE SECRETION. DIAGNOSIS OF GROWTH HORMONE DEFICIENCY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

SOHONOS(GHP)

MEDICATION(S)
SOHONOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FIBRODYSPLASIA OSSIFICANS PROGRESSIVE (FOP) AND DOCUMENTATION OF ACTIVIN A TYPE 1 RECEPTOR (ACVR1) R206H MUTATION.

AGE RESTRICTION
IF FEMALE: 8 YEARS OR OLDER, IF MALE: 10 YEARS OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH ENDOCRINOLOGIST OR PROVIDER SPECIALIZING IN CONNECTIVE TISSUE OR BONE DISEASES

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

SOMAVERT(GHP)

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of acromegaly AND either documentation of an inadequate or partial response to surgery or radiotherapy OR documentation of a clinical reason why the patient has not had surgery or radiotherapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorization will require documentation from prescriber indication improvement in condition OR documentation that patient's IGF-1 level has decreased or normalized since initiation of therapy.

SORIATANE(GHP)

MEDICATION(S)
ACITRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SEVERE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
DERMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE TOPICAL CORTICOSTEROID AND AT LEAST 2 TO 3 MONTHS OF METHOTREXATE OR PHOTOTHERAPY.

SPEVIGO(GHP)

MEDICATION(S)
SPEVIGO 450 MG/7.5ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF GENERALIZED PUSTULAR PSORIASIS (GPP) AND DOCUMENTATION OF A GPP FLARE OF MODERATE TO SEVERE INTENSITY AND ALL OF THE FOLLOWING: (1) GPP PHYSICIAN GLOBAL ASSESSMENT (GPPPGA) TOTAL SCORE OF GREATER THAN OR EQUAL TO 3 (MODERATE TO SEVERE) AND (2) GPPPGA PUSTULATION SUBSCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO VERY HIGH DENSITY PUSTULES) AND (3) PRESENCE OF FRESH PUSTULES (NEW APPEARANCE OR WORSENING OF PUSTULES) AND (4) GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA COVERED WITH ERYTHEMA AND PRESENCE OF PUSTULES. DOCUMENTATION OF A DOSE AND DURATION OF THERAPY THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED LITERATURE.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
DERMATOLOGIST

COVERAGE DURATION
1 WEEK

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT MEMBER IS EXPERIENCING PERSISTENT SYMPTOMS OF AN ACUTE GPP FLARE OF MODERATE TO SEVERE INTENSITY

AND ALL OF THE FOLLOWING: (1) GPPPGA TOTAL SCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO SEVERE) AND (2) GPPPGA PUSTULATION SUBSCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO VERY HIGH DENSITY PUSTULES) AND (3) SPEVIGO WILL BE ADMINISTERED NO SOONER THAN 1 WEEK AFTER THE INITIAL DOSAGE WAS ADMINISTERED AND (4) DOCUMENTATION THAT MEMBER HAS NOT ALREADY RECEIVED TWO DOSES OF SPEVIGO FOR TREATMENT OF GPP FLARE. TREATMENT OF NEW GPP FLARES WILL REQUIRE REEVALUATION OF COVERAGE FOR A NEW INITIAL APPROVAL REQUIRING DOCUMENTATION OF A GPP FLARE OF MODERATE TO SEVERE INTENSITY AND ALL OF THE FOLLOWING: (1) GPPPGA TOTAL SCORE OF GREATER THAN OR EQUAL TO 3 (MODERATE TO SEVERE) AND (2) GPPPGA PUSTULATION SUBSCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO VERY HIGH DENSITY PUSTULES) AND (3) PRESENCE OF FRESH PUSTULES (NEW APPEARANCE OR WORSENING OF PUSTULES) AND (4) GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA COVERED WITH ERYTHEMA AND PRESENCE OF PUSTULES AND (5) AT LEAST 12 WEEKS HAVE ELAPSED SINCE LAST DOSE OF SPEVIGO. ONE SUBSEQUENT APPROVAL OF SPEVIGO FOR TREATMENT OF PERSISTENT SYMPTOMS OF REPEAT GPP FLARE WILL BE GIVEN WHEN THE FOLLOWING IS MET: DOCUMENTATION THAT MEMBER IS EXPERIENCING PERSISTENT SYMPTOMS OF AN ACUTE GPP FLARE OF MODERATE TO SEVERE INTENSITY AND ALL OF THE FOLLOWING: (1) GPPPGA TOTAL SCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO SEVERE) AND (2) GPPPGA PUSTULATION SUBSCORE OF GREATER THAN OR EQUAL TO 2 (MODERATE TO VERY HIGH DENSITY PUSTULES) AND (3) SPEVIGO WILL BE ADMINISTERED NO SOONER THAN 1 WEEK AFTER THE INITIAL DOSAGE WAS ADMINISTERED.

SPRAVATO(GHP)

MEDICATION(S)
SPRAVATO (56 MG DOSE), SPRAVATO (84 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TREATMENT-RESISTANT MAJOR DEPRESSION DISORDER (MDD). DOCUMENTATION OF BASELINE DEPRESSION STATUS USING AN APPROPRIATE RATING SCALE (SUCH AS PHQ-9, CLINICALLY USEFUL DEPRESSION OUTCOME SCALE, QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY-SELF REPORT 16 ITEM, MADRS, HAM-D). DOCUMENTATION OF MAJOR DEPRESSION DISORDER AND DOCUMENTATION OF A RECENT HOSPITAL ADMISSION (WITHIN 4 WEEKS) DUE TO DEPRESSIVE SYMPTOMS WITH ACUTE SUICIDAL IDEATION AND BEHAVIOR.

AGE RESTRICTION
MUST BE 18 YEARS OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 MONTH INITIAL, 12 MONTHS CONTINUATION. MDD WITH SI: 1 MONTH

OTHER CRITERIA
DOCUMENTATION THAT SIGNIFICANT DRUG INTERACTIONS HAVE BEEN ADDRESSED BY THE PRESCRIBER (SUCH AS DISCONTINUATION OF THE INTERACTING DRUG, DOSE REDUCTION OF THE INTERACTING DRUG, OR COUNSELING OF THE BENEFICIARY ABOUT THE RISKS ASSOCIATED WITH THE USE OF BOTH MEDICATIONS WHEN THEY INTERACT). FOR TREATMENT RESISTANT MDD: DOCUMENTATION OF THERAPEUTIC FAILURE ON,

INTOLERANCE TO OR CONTRAINDICATION TO OLANZAPINE/FLUOXETINE CAPSULES. DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH A NEWLY INITIATED ANTIDEPRESSANT. TREATMENT-RESISTANT DEPRESSION AS DEFINED BY FAILURE OF AT LEAST TWO ANTIDEPRESSANTS FROM TWO DIFFERENT CLASSES AT AN OPTIMIZED DOSE FOR AT LEAST 6 WEEKS. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CLINICAL IMPROVEMENT IN DEPRESSION SYMPTOMS AS MEASURED BY AN APPROPRIATE RATING SCALE (COMPARED TO PREVIOUS MEASUREMENT). FOR MDD WITH SI: DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH AN ORAL ANTIDEPRESSANT AND DOCUMENTATION THAT DOSING DOES NOT EXCEED FDA APPROVED TREATMENT DURATION OF 4 WEEKS OR THAT THERAPY WAS INITIATED AS AN INPATIENT. MDD WITH SI REAUTHORIZATION BEYOND FDA TREATMENT DURATION WILL REQUIRE DOCUMENTATION OF PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

SPRYCEL(GHP)

MEDICATION(S)
SPRYCEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF NEWLY DIAGNOSED CHRONIC PHASE CML or DX OF CHRONIC, ACCELERATED, OR MYELOID/LYMPHOID BLAST PHASE Ph+ CML or DX OF Ph+ ALL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CHRONIC, ACCELERATED OR BLASTIC PHASE Ph+ CML - DOCUMENTATION OF RESISTANCE OR INTOLERANCE TO ONE PRIOR THERAPY, INCLUDING IMATINIB. FOR PH+ ALL - DOCUMENTATION OF RESISTANCE OR INTOLERANCE TO ONE PRIOR THERAPY or DOCUMENTATION OF USE TO TREAT NEWLY DIAGNOSED Ph+ ALL IN PEDIATRIC PATIENTS IN COMBINATION WITH CHEMOTHERAPY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

STELARA(GHP)

MEDICATION(S)
STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 45 MG/0.5ML SOLUTION, STELARA 90 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS. DX OF ACTIVE PSORIATIC ARTHRITIS WITH DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS. DX OF MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE. Diagnosis of moderately to severely active ulcerative colitis.

AGE RESTRICTION
FOR PP AND PSA: MUST BE 6 YEARS OF AGE OR OLDER, ALL OTHERS: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
DERMATOLOGIST, RHEUMATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PP (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA). PEDIATRIC PP (6 TO 18 YEARS OF AGE): DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR

CONTRAINDICATION TO TWO TOPICAL CORTICOSTEROIDS. FOR PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR PSA (COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, TREMFYA, RINVOQ, XELJANZ). PEDIATRIC PSA (6 TO 18 YEARS OF AGE): DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PREFERRED AGENTS FOR PSA (COSENTYX, HUMIRA,ENBREL). FOR CD: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED AGENTS FOR CD (HUMIRA, CIMZIA, SKYRIZI, INFLIXIMAB). FOR UC: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR UC (HUMIRA, SIMPONI, XELJANZ, RINVOQ). FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

STIMUFEND(GHP)

MEDICATION(S)
STIMUFEND

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESIVE CHEMO REGIMEN IS 20% OR GREATER OR TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH ONE ADDITIONAL RISK FACTOR. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
ADDITIONAL RISK FACTORS FOR THE PREVENTION OF FEBRILE NEUTROPENIA INCLUDE, BUT ARE NOT LIMITED TO: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OR CHEMOTHERAPY

TREATMENT, POOR NUTRITIONAL STATUS, RECENT SURGERY OR OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER, PERSISTENT NEUTROPENIA, BONE MARROW INVOLVEMENT BY TUMOR, LIVER DYSFUNCTION (BILIRUBIN GREATER THAN 2), OR RENAL DYSFUNCTION (CrcL LESS THAN 50 ML/MIN).

STIVARGA(GHP)

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC COLORECTAL CANCER OR DOCUMENTATION OF LOCALLY ADVANCED, UNRESTECTABLE OR METASTATIC GASTROINTESTINAL STROMAL TUMOR (GIST). DOCUMENTATION OF HEPATOCELLULAR CARCINOMA WITH FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO SORAFENIB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR METASTATIC COLORECTAL CANCER: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THREE OF THE FOLLOWING PRIOR THERAPIES (BASED ON CLINICAL TRIAL DESIGN) - FLUOROPYRIMIDINE BASED CHEMO, OXALIPLATIN BASED CHEMO, IRINOTECAN BASED CHEMO, ANTI-VEGF THERAPY (BEVACIZUMAB) OR IF KRAS WILD TYPE AN ANTI-EGFR THERAPY (CETUXIMAB OR PANITUMUMAB). FOR GIST: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO IMATINIB MESYLATE (GLEEVEC) AND SUNITINIB MALATE (SUTENT). REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

STRATTERA(GHP)

MEDICATION(S)
ATOMOXETINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ADD/ADHD

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

STRENSIQ(GHP)

MEDICATION(S)
STRENSIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PERINATAL- OR INFANTILE- OR JUVENILE-ONSET HYPOPHOSPHATASIA (HPP) AND DOCUMENTATION OF LOW TOTAL SERUM ALKALINE PHOSPHATASE ACTIVITY AND DOCUMENTATION THAT MEMBER WILL RECEIVE A WEIGHT AND DIAGNOSIS APPROPRIATE DOSING REGIMEN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST, GENETICIST OR METABOLIC SPECIALIST

COVERAGE DURATION
3 MONTH INITIAL AND 12 MONTH CONTINUATION

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 3 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

SUCRAID(GHP)

MEDICATION(S)
SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CONGENITAL SUCRASE-ISOMALTASE DEFICIENCY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

SULFONYLUREAS HRM(GHP)

MEDICATION(S)
GLYBURIDE 1.25 MG TAB, GLYBURIDE 2.5 MG TAB, GLYBURIDE 5 MG TAB, GLYBURIDE MICRONIZED, GLYBURIDE-METFORMIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO GLIPIZIDE

SUNOSI(GHP)

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of excessive daytime sleepiness associated with either narcolepsy or obstructive sleep apnea.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For sleepiness associated with narcolepsy: documentation of therapeutic failure on, intolerance to, or contraindication to either modafinil or armodafinil AND methylphenidate IR or amphetamine-dextroamphetamine IR. For sleepiness associated with obstructive sleep apnea: documentation that underlying airway obstruction has been treated for at least one month prior to initiation of therapy, and will continue to be treated AND documentation of a therapeutic failure on, intolerance to, or contraindication to modafinil or armodafinil.

SUTENT(GHP)

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF GASTROINTESTINAL STROMAL TUMOR (GIST). DX OF PROGRESSIVE, WELL-DIFFERENTIATED PANCREATIC NEUROENDOCRINE TUMORS (pNET) WITH UNRESECTABLE LOCALLY ADVANCED OR METASTATIC DISEASE. DX OF ADVANCED RENAL CELL CARCINOMA. DX OF ADJUVANT TREATMENT OF RENAL CELL CARCINOMA WITH HIGH RISK OF RECURRENT DISEASE FOLLOWING NEPHRECTOMY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR GASTROINTESTINAL STROMAL TUMOR THERE MUST BE A FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO IMATINIB. SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

SYLVANT(GHP)

MEDICATION(S)
SYLVANT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTICENTRIC CASTLEMAN DISEASE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PATIENT IS HIV AND HHV-8 NEGATIVE AND DOCUMENTATION OF ANC GREATER THAN 1 X 1000000000 (10 TO THE 9TH POWER) / L AND PLATELETS GREATER THAN 75 X 1000000000 (10 TO THE 9TH POWER) / L AND HGB LESS THAN 17 G/DL. SUBSEQUENT APPROVAL AFTER 6 MONTHS WILL REQUIRE DOCUMENTATION OF NO DISEASE PROGRESSION AND THE FOLLOWING CRITERIA, ANC GREATER THAN 1 X 1000000000 (10 TO THE 9TH POWER) / L AND PLATELETS GREATER THAN 50 X 1000000000 (10 TO THE 9TH POWER) / L AND HGB LESS THAN 17 G/DL.

SYMDEKO(GHP)

MEDICATION(S)
SYMDEKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of cystic fibrosis AND documentation as evidenced by an FDA cleared CF mutation test of at least one mutation in CFTR gene that is responsive to tezacaftor/ivacaftor per product labeling OR documentation that the member is homozygous for the F508del CFTR mutation.

AGE RESTRICTION
MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CYSTIC FIBROSIS SPECIALIST

COVERAGE DURATION
4 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
Reauthorization will require documentation of improvement or stabilization in the signs of symptoms of cystic fibrosis.

SYMLIN(GHP)

MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL RECORD DOCUMENTATION OF USE AS AN ADJUNCT TREATMENT IN PATIENT'S WHO USE MEALTIME INSULIN THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE TO ACHIEVE DESIRED CONTROL DESPITE OPTIMAL MEALTIME INSULIN THERAPY, WHICH MAY BE WITH OR WITHOUT A CONCURRENT SULFONYLUREA AND/OR METFORMIN FOR THOSE WITH TYPE 2 DM

SYMPAZAN(GHP)

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF LENNOX-GASTAUT SYNDROME

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to at least two prior anti-epileptic therapies for the treatment of Lennox-Gastaust, one of which must be clobazam tablets or solution

SYNAGIS(GHP)

MEDICATION(S)
SYNAGIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PROPHYAXIS OF SERIOUS LOWER RESPIRATORY TRACT DISEASE CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV) IN PEDIATRIC PATIENTS AT HIGH RISK, INCLUDING THOSE WITH BRONCHOPULMONARY DYSPLASIA OR COGENITAL HEART DISEASE, AND THOSE BORN PREMATURELY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
5 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEMBER HAS NOT RECEIVED BEYFORTUS DURING THE CURRENT RSV SEASON.

SYNERCID(GHP)

MEDICATION(S)
SYNERCID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF COMPLICATED SKIN AND SKIN STRUCTURE INFECTIONS CAUSED BY STREPTOCOCCUS PYOGENES OR METHICILLIN-SENSITIVE STAPHYLOCOCCUS AUREUS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST OR UPON CONSULT FROM INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

SYNRIBO(GHP)

MEDICATION(S)
SYNRIBO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC OR ACCELERATED PHASE CHRONIC MYELOID LEUKEMIA (CML)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OR MORE TYROSINE KINASE INHIBITORS (GLEEVEC, SPRYCEL, TASIGNA, BOSULIF). REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TABRECTA(GHP)

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TAFAMIDIS MEGLUMINE(GHP)

MEDICATION(S)
VYNDAMAX, VYNDAQEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of cardiomyopathy resulting from wild type transthyretin-mediated amyloidosis OR hereditary transthyretin-mediated amyloidosis as confirmed by ONE of the following: 1) bone scan (scintigraphy) strongly positive for myocardial uptake of 99mTcPYP/DPD or 2) biopsy of tissue of the affected organ to confirm amyloid presence and chemical typing to confirm presence of transthyretin (TTR) protein.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a cardiologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of NYHA Class I, II, or III heart failure. Reauthorizations will require prescriber attestation that the patient continues to benefit from tafamidis therapy AND no documenTation of NYHA class IV heart failure.

TAFINLAR(GHP)

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic melanoma with one of the following: documentation for use as single therapy OR documentation of use in combination with Mekinist (trametinib). Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test. Diagnosis of metastatic non-small cell lung cancer with concomitant use of Mekinist AND documentation of BRAF V600E mutation as detected by an FDA-approved test. Diagnosis of use for adjuvant treatment of melanoma with involvement of lymph nodes following complete resection AND documentation of concurrent use Mekinist (trametinib) AND documentation of BRAF V600E or V600K mutation. Diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND documentation of concurrent use of Mekinist (trametinib) AND documentation of BRAF V600E mutation. Documentation of unresectable or metastatic solid tumors AND documentation of BRAF V600E mutation. Documentation of low-grade glioma (LGG) AND documentation of BRAF V600E mutation AND documentation of concurrent use of Mekinist (trametinib)

AGE RESTRICTION
For LGG: age greater than or equal to one year and less than 18 years.

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

FOR UNRESECTABLE OR SOLID TUMORS, DOCUMENTATION OF PREVIOUS TREATMENT RESULTING IN DISEASE PROGRESSION AND DOCUMENTATION OF USE IN COMBINATION WITH MEKINIST. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TAGRISSO(GHP)

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC EGFR T790M MUTATION POSITIVE NON SMALL CELL LUNG CANCER AS DETECTED BY AN FDA APPROVED TEST with DOCUMENTATION OF FAILURE ON OR INTOLERANCE TO PRIOR TYROSINE KINASE INHBITOR THERAPY (IRESSA, GILOTRIF, OR TARCEVA). DOCUMENTATION OF USE AS FIRST LINE THERAPY FOR METASTATIC NON-SMALL CELL LUNG CANCER WITH EITHER (1) EGFR EXON 19 DELETION OR EXON 21 L858R MUTATION AS DETECTED BY AN FDA APPROVED TEST OR (2) USED IN COMBINATION WITH PEMETREXED AND PLATINUM BASED CHEMOTHERAPY FOR METASTATIC OR LOCALLY NON-SMALL CELL LUNG CANCER. DOCUMENTATION OF ADJUVANT TREAMENT FOLLOWING COMPLETE TUMOR RESECTION OF NON-SMALL CELL LUNG CANCER WITH EGFR EXON 19 DELETION OR EXON 21 L858R MUTATION AS DETECTED BY AN FDA APPROVED TEST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF

CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. ADJUVANT TREATMENT OF NON-SMALL CELL LUNG CANCER BEYOND 3 YEARS WILL REQUIRE DOCUMENTATION THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

TAKHZYRO(GHP)

MEDICATION(S)
TAKHZYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF HEREDITARY ANGIOEDEMA and FOR HAE TYPE I AND TYPE II: THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDMEA WITHOUT URTICARIA SUPPORTED BY DOCUMENTATION OF LOW C4 LEVELS AND LESS THAN 50 PERCENT OF THE LOWER LIMIT OF NORMAL C1-INH ANTIGENIC PROTEIN LEVELS OR FUNCTION LEVELS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS BEING USED AS PROPHYLACTIC THERAPY. Documentation that medication is not being used in combination with another prophylactic human C1 esterase inhibitor (Cinryze or Haegarda) or berotralstat (Orladeyo) therapy for hereditary angioedema.REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TALVEY(GHP)

MEDICATION(S)
TALVEY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA AND DOCUMENTATION OF TREATMENT WITH AT LEAST 4 PRIOR LINES OF THERAPY, INCLUDING A PROTEASOME INHIBITOR, AN IMMUNOMODULATORY AGENT, AND AN ANTI-CD38 MONOCLONAL ANTIBODY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TALZENNA(GHP)

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) HER2-negative locally advanced or metastatic breast cancer as verified by an FDA approved test. DIAGNOSIS OF HOMOLOGOUS RECOMBINATION REPAIR (HRR) GENE-MUTATED METASTATIC CASTRATION-RESISTANT PROSTATE CANCER AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH ENZALUTAMIDE (XTANDI).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorization will require documentation of continued disease improvement or lack of disease progression.

TARCEVA(GHP)

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH ONE OF THE FOLLOWING: USED AS FIRST LINE TREATMENT or MAINTENANCE TREATMENT or SECOND LINE OR GREATER TREATMENT AFTER PROGRESSION ON AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN. DOCUMENTATION OF ONE OF THE FOLLOWING EGFR MUTATIONS AS DETECTED BY AN FDA APPROVED TEST: EXON 19 DELETION OR EXON 21 (L858R) SUBSTITUTION. DOCUMENTATION OF LOCALLY ADVANCED, UNRESECTABLE OR METASTASIZED PANCREATIC CANCER IN COMBO THERAPY WITH GEMCITABINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TARPEYO(GHP)

MEDICATION(S)
TARPEYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN) VERIFIED BY BIOPSY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEPHROLOGIST

COVERAGE DURATION
10 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PATIENT IS AT HIGH RISK OF DISEASE PROGRESSION. DOCUMENTATION OF EGFR GREATER THAN OR EQUAL TO 35 ML/MIN/1.73 M2. DOCUMENTATION THAT PATIENT HAS RECEIVED A STABLE DOSE OF A RAS INHIBITOR AT A MAXIMALLY TOLERATED DOSE FOR GREATER THAN OR EQUAL TO 90 DAYS. DOCUMENTATION THAT A RAS INHIBITOR WILL BE USED IN COMBINATION WITH TARPEYO. DOCUMENTATION THAT MEMBER HAS NOT PREVIOUSLY COMPLETED A 9 MONTH TREATMENT COURSE OF TARPEYO. DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A GLUCOCORTICOID.

TASIGNA(GHP)

MEDICATION(S)
TASIGNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF NEWLY DIAGNOSED (NOT PREVIOUSLY TREATED) CHRONIC PHASE PH+ CML. DIAGNOSIS OF ADULT CHRONIC OR ACCELERATED PHASE PH+ CML IN PATIENT'S RESISTENT TO, OR INTOLERANT TO PRIOR THERAPY INCLUDING GLEEVEC. DIAGNOSIS OF CHRONIC OR ACCELERATED PHASE PH+ CML IN PEDIATRIC PATIENT'S RESISTENT TO, OR INTOLERANT TO PRIOR TYROSINE KINASE INHIBITOR THERAPY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TAVALISSE(GHP)

MEDICATION(S)
TAVALISSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA AND DOCUMENTATION OF A PLATELET COUNT LESS THAN 30,000/MICROL.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with a hematologist

COVERAGE DURATION
3 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CORTICOSTEROIDS, IVIG, RHOGAM (IF RHD-POSITIVE AND SPLEEN INTACT), RITUXIMAB, SPLENECTOMY, ELTROMBOPAG OR ROMIPLOSTIM OR AVATROMBOPAG. SUBSEQUENT APPROVAL AFTER 3 MONTHS WILL REQUIRE DOCUMENTATION OF MEDICAL NECESSITY SUCH AS A PLATELET COUNT NECESSARY TO REDUCE THE RISK FOR BLEEDING.

TAVNEOS(GHP)

MEDICATION(S)
TAVNEOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF SEVERE ACTIVE ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS CLASSIFIED AS ONE OF THE FOLLOWING VARIANTS: GRANULOMATOSIS WITH POLYANGIITIS (GPA) OR MICROSCOPIC POLYANGIITIS (MPA) AND ADMINISTERED IN COMBINATION WITH STANDARD THERAPY SUCH AS, BUT NOT LIMITED TO RITUXIMAB, CYCLOPHOSPHAMIDE, METHOTREXATE, MYCOPHENOLATE, OR AZATHIOPRINE, AND/OR GLUCOCORTICOIDS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF A POSITIVE TEST FOR ANTI-PROTEINASE 3 (PR3) OR ANTI-MYELOPEROXIDASE (MPO) AND DOCUMENTATION OF AT LEAST 1 MAJOR ITEM, 3 NON-MAJOR ITEMS, OR 2 RENAL ITEMS OF PROTEINURIA AND HEMATURIA ON THE BIRMINGHAM VASCULITIS ACTIVITY SCORE (BVAS). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND DOCUMENTATION THAT THE MEMBER IS RESPONDING POSITIVELY TO THERAPY AS

EVIDENCED BY A REDUCTION IN THE BIRMINGHAM VASCULITIS ACTIVITY SCORE (BVAS) AND RECORD DOCUMENTATION THAT TAVNEOS WILL CONTINUE TO BE ADMINISTERED IN COMBINATION WITH STANDARD THERAPY SUCH AS, BUT NOT LIMITED TO RITUXIMAB, CYCLOPHOSPHAMIDE, METHOTREXATE, MYCOPHENOLATE, OR AZATHIOPRINE, AND/OR GLUCOCORTICOIDS.

TAZORAC(GHP)

MEDICATION(S)
TAZAROTENE 0.05 % GEL, TAZAROTENE 0.1 % CREAM, TAZAROTENE 0.1 % GEL, TAZORAC 0.05 % CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ACNE, ACNE VULGARIS, ADULT ONSET ACNE, OR PLAQUE PSORIASIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR ACNE: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY TOPICAL RETINOIDS, INCLUDING BUT NOT LIMITED TO ADAPALENE AND TRETINOIN. FOR PSORIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE TOPICAL CORTICOSTEROID AND AT LEAST 2 TO 3 MONTHS OF METHOTREXATE OR PHOTOTHERAPY.

TAZVERIK(GHP)

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of metastatic or locally advanced epithelioid sarcoma AND documentation that member is not eligible for complete resection. Diagnosis of relapsed or refractory follicular lymphoma with documentation of one of the following: 1)documentation of an EZH2 mutation as detected by an FDA approved test with documentation of trial of at least two prior systemic therapies OR 2)documentation of no satisfactory alternative treatment options.

AGE RESTRICTION
SARCOMA: 16 YRS OR OLDER. LYMPHOMA: 18 YRS OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

TCA HRM(GHP)

MEDICATION(S)
AMITRIPTYLINE HCL 10 MG TAB, AMITRIPTYLINE HCL 100 MG TAB, AMITRIPTYLINE HCL 150 MG TAB, AMITRIPTYLINE HCL 25 MG TAB, AMITRIPTYLINE HCL 50 MG TAB, AMITRIPTYLINE HCL 75 MG TAB, AMOXAPINE, CHLORDIAZEPOXIDE-AMITRIPTYLINE, DOXEPIN HCL 10 MG CAP, DOXEPIN HCL 10 MG/ML CONC, DOXEPIN HCL 100 MG CAP, DOXEPIN HCL 150 MG CAP, DOXEPIN HCL 25 MG CAP, DOXEPIN HCL 50 MG CAP, DOXEPIN HCL 75 MG CAP, IMIPRAMINE HCL 10 MG TAB, IMIPRAMINE HCL 25 MG TAB, IMIPRAMINE HCL 50 MG TAB, IMIPRAMINE PAMOATE, PERPHENAZINE-AMITRIPTYLINE, PROTRIPTYLINE HCL, TRIMIPRAMINE MALEATE 100 MG CAP, TRIMIPRAMINE MALEATE 25 MG CAP, TRIMIPRAMINE MALEATE 50 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE DOCUMENTATION OF AN FDA LABELED INDICATION AND DOCUMENTATION THAT THE PRESCRIBER HAS INDICATED THAT THE BENEFITS OF THE REQUESTED HIGH RISK

MEDICATION OUTWEIGHS THE RISKS FOR THE PATIENT AND DOCUMENTATION THAT THE PROVIDER DISCUSSED THESE RISKS AND POTENTIAL SIDE EFFECTS OF THE REQUESTED HIGH RISK MEDICATION WITH THE PATIENT.

TECENTRIQ(GHP)

MEDICATION(S)
TECENTRIQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF NON SMALL CELL LUNG CANCER MEETING ONE OF THE FOLLOWING:1)DISEASE PROGRESSION DURING OR FOLLOWING PLATINUM CONTAINING CHEMOTHERAPY OR 2)PROGRESSION ON AT LEAST ONE FDA APPROVED THERAPY TARGETING EGFR OR ALK IF THE PATIENT HAS EGFR OR ALK GENOMIC TUMOR ABERRATIONS OR 3)DOCUMENTATION OF NON-SQUAMOUS HISTOLOGIC SUBTYPE USED AS FIRST LINE IN COMBINATION WITH EITHER 1)BEVACIZUMAB, PACLITAXEL AND CARBOPLATIN OR 2) PACLITAXEL PROTEIN-BOUND AND CARBOPLATIN WITH NO EGFR OR ALK GENOMIC TUMOR ABERRATIONS OR 4)AS FIRST LINE TREATMENT FOR METASTATIC DISEASE WITH HIGH PD-L1 EXPRESSION (PD-L1 STAINED TUMOR CELLS OF AT LEAST 50% OR PD-L1 STAINED TUMOR INFILTRATING IMMUNE CELLS COVERING 10% OR MORE OF THE TUMOR AREA AS DETERMINED BY AN FDA APPROVED TEST) AND DOCUMENTATION OF NO EGFR OR ALK GENOMIC TUMOR ABERRATIONS OR 5) ADJUVANT TREATMENT AS A SINGLE AGENT FOR STAGE II TO IIIA DISEASE FOLLOWING RESECTION AND PLATINUM BASED THERAPY AND WHOSE TUMORS HAVE PD-L1 EXPRESSION ON AT LEAST 1% OF TUMOR CELLS AS DETERMINED BY AN FDA APPROVED TEST. DX OF USE AS FIRST LINE TREATMENT FOR EXTENSIVE STAGE SMALL CELL LUNG CANCER (ES-SCLC) AND DOCUMENTATION OF USE IN COMBINATION WITH CARBOPLATIN AND ETOPOSIDE. DX OF UNRESECTABLE OR METASTATIC HEPATOCELLULAR CARCINOMA (HCC) USED IN COMBINATION WITH BEVACIZUMAB AND DOCUMENTATION OF NO PRIOR SYSTEMIC TREATMENT FOR HCC. DX OF UNRESECTABLE OR METASTATIC MELANOMA WITH DOCUMENTATION OF BRAF V600 MUTATION AS DETERMINED BY AN FDA APPROVED TEST AND DOCUMENTATION OF USE IN COMBINATION WITH COBIMETINIB AND VEMURAFENIB. DX OF UNRESECTABLE OR METASTATIC ALVEOLAR SOFT PART SARCOMA

(ASPS).

AGE RESTRICTION
FOR ASPS: MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVALS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. AUTHORIZATION BEYOND 12 MONTHS FOR ADJUVANT TREATMENT OF STAGE II TO IIIA NSCLC FOLLOWING RESECTION AND PLATINUM BASED CHEMOTHERAPY WILL REQUIRE PEER REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

TECVAYLI(GHP)

MEDICATION(S)
TECVAYLI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED OR REFRACTORY MULTIPLE MYELOMA AND TREAMENT WITH AT LEAST 4 PRIOR LINES OF THERAPY, INCLUDING A PROTEASOME INHIBITOR, AN IMMUNOMODULATORY AGENT, AND AN ANTI-CD38 MONOCLONAL ANTIBODY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TEGSEDI(GHP)

MEDICATION(S)
TEGSEDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR) as confirmed by genetic testing to confirm a pathogenic mutation in TTR AND documentation of either biopsy of tissue or organ to confirm amyloid presence OR a clinical manifestation typical of hATTR (such as neuropathy or CHF) without a better alternative explanation. Documentation of medication being used to treat polyneuropathy. Documentation of familial amyloid polyneuropathy (FAP) stage 1-2 OR polyneuropathy disability score indicating the patient is not wheelchair bound or bedridden.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
By or in consultation with neurologist, board certified medical geneticist, or specialist with experience treating hATTR

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that medication will not be used in combination with other RNA interference treatments. Reauthorization will require medical necessity and no documentation of FAP stage 3 OR polyneuropathy disability score indicating the patient is wheelchair-bound or bedridden.

TEPEZZA(GHP)

MEDICATION(S)
TEPEZZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF GRAVE'S DISEASE AND DOCUMENTATION OF MODERATE TO SEVERE THYROID EYE DISEASE WITH DOCUMENTATION OF ONE OR MORE OF THE FOLLOWING: 1)LID RETRACTION OF GREATER THAN OR EQUAL TO 2 MM 2) MODERATE OR SEVERE SOFT-TISSUE INVOLVEMENT 3) PROPTOSIS GREATER THAN OR EQUAL TO 3 MM ABOVE NORMAL VALUES FOR RACE AND SEX, 4) PERIODIC OR CONSTANT DIPLOPIA

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
OPHTHALMOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEMBER IS EUTHYROID OR HAS MILD HYPO- OR HYPERTHYROIDISM (FREE T4 AND FREE T3 LEVELS LESS THAN 50% ABOVE OR BELOW NORMAL LIMITS PRIOR TO STARTING TEPEZZA THERAPY. DOCUMENTATION OF BEING PRESCRIBED AN APPROPRIATE DOSE AND DURATION OF TEPEZZA PER PRODUCT LABELING. DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SYSTEMIC STEROIDS. REQUESTS FOR AUTHORIZATIONS

EXCEEDING 8 TOTAL DOSES WILL REQUIRE DOCUMENTATION OF PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS INDICATING THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

TEPMETKO(GHP)

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TEZSPIRE(GHP)

MEDICATION(S)
TEZSPIRE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SEVERE ASTHMA AND DOCUMENTATION THAT MEDICATION WILL BE USED AS AN ADD-ON MAINTENANCE TREATMENT.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ALLERGIST, IMMUNOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED IN COMBINATION WITH BENRALIZUMAB, DUPILUMAB, MEPOLIZUMAB, OMALIZUMAB OR RESLIZUMAB. DOCUMENTATION OF ONE OF THE FOLLOWING: 1)INTOLERANCE TO, OR POORLY CONTROLLED SYMPTOMS DESPITE A 3 MONTH TRIAL OF: MEDIUM TO HIGH DOSE INHALED CORTICOSTEROIDS AND ANOTHER CONTROLLER MEDICATION (I.E, LONG-ACTING BETA AGONISTS, LONG-ACTING MUSCARINIC ANTAGONIST, OR LEUKOTRIENE RECEPTOR ANTAGONIST) WITH OR WITHOUT ORAL SYSTEMIC CORTICOSTEROIDS OR 2) TWO OR MORE EXACERBATIONS REQUIRING SYSTEMIC CORTICOSTEROID TREATMENT OR ONE EXACERBATION RESULTING IN HOSPITALIZATION IN THE PAST 12 MONTHS DESPITE CURRENT THERAPY OF MEDIUM TO HIGH DOSE INHALED CORTICOSTEROIDS AND ANOTHER

CONTROLLER MEDICATION (I.E, LONG-ACTING BETA AGONISTS, LONG-ACTING MUSCARINIC ANTAGONIST, OR LEUKOTRIENE RECEPTOR ANTAGONIST). SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

THIORIDAZINE HRM(GHP)

MEDICATION(S)
THIORIDAZINE HCL 10 MG TAB, THIORIDAZINE HCL 100 MG TAB, THIORIDAZINE HCL 25 MG TAB, THIORIDAZINE HCL 50 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ARIPIPRAZOLE)

TIBSOVO(GHP)

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1)DIAGNOSIS OF RELAPSED OR REFRACTORY ACUTE MYELOID LEUKEMIA WITH DOCUMENTATION OF AN ISOCITRATE DEHYDROGENASE-1 (IDH1) MUTATION AS DETECTED BY AN FDA APPROVED TEST OR 2)DIAGNOSIS OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA IN MEMBERS GREATER THAN OR EQUAL TO 75 YEARS OF AGE OR IN THOSE WITH COMORBIDITIES THAT PRECLUDE THE USE OF INTENSIVE INDUCTION CHEMOTHERAPY AND DOCUMENTATION OF AN ISOCITRATE DEHYDROGENASE-1 (IDH1) MUTATION AS DETECTED BY AN FDA APPROVED TEST AND DOCUMENTATION OF USE AS MONOTHERAPY OR IN COMBINATION WITH AZACITIDINE 3)DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC CHOLANGIOCARCINOMA AND DOCUMENTATION OF AN ISOCITRATE DEHYDROGENASE-1 (IDH1) MUTATION AS DETECTED BY AN FDA APPROVED TEST AND DOCUMENTATION OF TREATMENT WITH AT LEAST ONE PRIOR THERAPY OR 4) DOCUMENTATION OF RELAPSED OR REFRACTORY MYELODYSPLASTIC SYNDROMES (MDS) AND DOCUMENTATION OF AN ISOCITRATE DEHYDROGENASE-1 (IDH1) MUTATION AS DETECTED BY AN FDA-APPROVED TEST.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

Reauthorizations will require documentation of continued disease improvement or lack of disease progression

TIGLUTIK(GHP)

MEDICATION(S)
TEGLUTIK, TIGLUTIK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of ALS (amyotrophic lateral sclerosis)

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to riluzole tablets OR documentation that the patient has dysphagia or is unable to swallow tablets.

TIVDAK(GHP)

MEDICATION(S)
TIVDAK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RECURRENT OR METASTATIC CERVICAL CANCER AND DOCUMENTATION OF DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TLANDO(GHP)

MEDICATION(S)
TLANDO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR TESTOSTERONE REPLACEMENT THERAPY IN ADULT MALES FOR CONDITIONS ASSOCIATED WITH A DEFICIENCY OR ABSENCE OF ENDOGENOUS TESTOSTERONE: PRIMARY HYPOGONADISM (CONGENITAL OR ACQUIRED) OR HYPOGONADOTROPIC HYPOGONADISM (CONGENITAL OR ACQUIRED).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANDROGEN ALTERNATIVES.

TOBI(GHP)

MEDICATION(S)
TOBI PODHALER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CYSTIC FIBROSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

TOBRAMYCIN NEB(GHP)

MEDICATION(S)
TOBRAMYCIN 300 MG/5ML NEBU SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF CYSTIC FIBROSIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

TORISEL(GHP)

MEDICATION(S)
TEMSIROLIMUS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ADVANCED RENAL CELL CARCINOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TRACLEER(GHP)

MEDICATION(S)
BOSENTAN, TRACLEER 32 MG TAB SOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF FUNCTIONAL CLASS 2, 3, OR 4 PULMONARY ARTERIAL HYPERTENSION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

TREMFYA(GHP)

MEDICATION(S)
TREMFYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF MODERATE TO SEVERE PLAQUE PSORIASIS CHARACTERIZED BY 5% OR GREATER INVOLVEMENT OF BODY SURFACE AREA OR DISEASE INVOVLING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS. DOCUMENTATION OF ACTIVE PSORIATIC ARTHRITIS. DX OF PERIPHERAL PSA OR AXIAL PSA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR PP: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROID AND AT LEAST 3 MONTHS OF ONE SYSTEMIC THERAPY SUCH AS BUT NOT LIMITED TO METHOTREXATE OR CYCLOSPORINE OR PHOTOTHERAPY. FOR PERIPHERAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ONE FORMULARY NSAID AND METHOTREXATE. FOR AXIAL PSA: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO

FORMULARY NSAIDS. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

TRETINOIN(GHP)

MEDICATION(S)
TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.05 % GEL, TRETINOIN 0.1 % CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF ACNE, ACNE VULGARIS, OR ADULT ONSET ACNE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

TREXIMET(GHP)

MEDICATION(S)
SUMATRIPTAN-NAPROXEN SODIUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MIGRAINE.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR 18 YEARS OF AGE OR OLDER: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO FORMULARY TRIPTANS (ONE OF WHICH MUST BE SUMATRIPTAN) USED IN COMBINATION WITH NAPROXEN. FOR 12 TO 18 YEARS OF AGE: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BOTH OF THE FOLLOWING: (1) RIZATRIPTAN USED IN COMBINATION WITH NAPROXEN AND (2) ALMOTRIPTAN USED IN COMBINATION WITH NAPROXEN.

TRIKAFTA(GHP)

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CYSTIC FIBROSIS AND DOCUMENTATION OF ONE OF THE FOLLOWING: (1) AT LEAST ONE F508DEL MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE AS DETERMINED BY AN FDA-CLEARED CYSTIC FIBROSIS MUTATION TEST OR (2) DOCUMENTATION OF A MUTATION IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) GENE AS DETERMINED BY AN FDA-CLEARED CYSTIC FIBROSIS MUTATION TEST THAT IS RESPONSIVE BASED ON IN VITRO DATA PER PRODUCT LABELING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
By or in consultation with a pulmonologist or physician who specializes in the treatment of CF

COVERAGE DURATION
4 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OR STABILIZATION IN THE SIGNS AND SYMPTOMS OF CYSTIC FIBROSIS.

TRINTELLIX(GHP)

MEDICATION(S)
TRINTELLIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTION
MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES.

TRIPTODUR(GHP)

MEDICATION(S)
TRIPTODUR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CENTRAL PRECOCIOUS PUBERTY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH ENDOCRINOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LUPRON DEPOT-PED

TRODELVY(GHP)

MEDICATION(S)
TRODELVY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF UNRESECTABLE LOCALLY ADVANCED OR METASTATIC TRIPLE NEGATIVE BREAST CANCER WITH DOCUMENTATION OF TRIAL OF AT LEAST TWO PREVIOUS LINES OF SYSTEMIC THERAPY, OF WHICH AT LEAST ONE WAS FOR METASTATIC DISEASE. DOCUMENTATION OF DIAGNOSIS OF UNRESECTABLE LOCALLY ADVANCED OR METASTATIC HORMONE RECEPTOR (HR) POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE (IHC 0, IHC 1+ OR IHC 2+/ISH-) BREAST CANCER AND DOCUMENTATION OF PREVIOUSLY RECEIVING ENDOCRINE-BASED THERAPY AND DOCUMENTATION OF PREVIOUSLY RECEIVING AT LEAST TWO ADDITIONAL SYSTEMIC THERAPIES IN THE METASTATIC SETTING. DOCUMENTATION OF DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER AND DOCUMENTATION OF PROGRESSION ON PLATINUM-CONTAINING CHEMOTHERAPY AND DOCUMENTATION OF PROGRESSION ON A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PDL1) INHIBITOR.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA

REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TROKENDI XR(GHP)

MEDICATION(S)
TOPIRAMATE ER 100 MG CAP ER 24H, TOPIRAMATE ER 200 MG CAP ER 24H, TOPIRAMATE ER 25 MG CAP ER 24H, TOPIRAMATE ER 50 MG CAP ER 24H

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES, PRIMARY GENERALIZED TONIC CLONIC SEIZURES, OR LENNOX GASTAUT SYNDROME or DIAGNOSIS OF MIGRAINE PROPHYLAXIS

AGE RESTRICTION
12 YEARS OR OLDER FOR MIGRAINE PROPHYLAXIS, 6 YEARS OF AGE OR OLDER FOR OTHER INDICATIONS

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTICONVULSANTS USED FOR THE REQUESTED DIAGNOSIS, ONE OF WHICH MUST BE IMMEDIATE-RELEASE TOPIRAMATE.

TRUQAP(GHP)

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC BREAST CANCER THAT IS HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE AND DOCUMENTATION OF ONE OR MORE PIK3CA, AKT1, OR PTEN-ALTERATION DETERMINED USING AN FDA-APPROVED TEST AND DOCUMENTATION OF USE IN COMBINATION WITH FULVESTRANT AND DOCUMENTATION OF ONE OF THE FOLLOWING: (1) FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PRIOR ENDOCRINE THERAPY OR (2) RECURRENCE ON OR WITHIN 12 MONTHS OF COMPLETING ADJUVANT THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

TRUSELTIQ(GHP)

MEDICATION(S)
TRUSELTIQ (100MG DAILY DOSE), TRUSELTIQ (125MG DAILY DOSE), TRUSELTIQ (50MG DAILY DOSE), TRUSELTIQ (75MG DAILY DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF UNRESECTABLE LOCALLY ADVANCED OR METASTATIC CHOLANGIOCARCINOMA AND DOCUMENTATION OF A FIBROBLAST GROWTH FACTOR RECEPTOR 2 (FGFR2) FUSION OR OTHER REARRANGEMENT AS VERIFIED BY AN FDA APPROVED TEST AND DOCUMENTATION OF TRIAL OF ONE PRIOR LINE OF THERAPY

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TUKYSA(GHP)

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of advanced unresectable or metastatic HER2-positive breast cancer, including those with brain metastases AND documentation of prior treatment with at least one anti-HER2 based regimen in the metastatic setting. DIAGNOSIS OF RAS WILD-TYPE HER2-POSITIVE UNRESECTABLE OR METASTATIC COLORECTAL CANCER AND DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBO W/ TRASTUZUMAB AND DOCUMENTATION OF PRIOR TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR BREAST CANCER: DOCUMENTATION THAT MEDICATION WILL BE GIVEN IN COMBINATION WITH TRASTUZUMAB AND CAPECITABINE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

TURALIO(GHP)

MEDICATION(S)
TURALIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of tenosynovial giant cell tumor that meets both of the following criteria 1) associated with functional limitations or severe morbidity and 2) that condition is not amenable to improvement with surgery.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TYKERB(GHP)

MEDICATION(S)
LAPATINIB DITOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE IN COMBINATION WITH LETROZOLE FOR THE TREATMENT OF POSTMENOPAUSAL WOMEN WITH HORMONE RECEPTOR-POSITIVE, HER2+ METASTATIC BREAST CANCER OR DOCUMENTATION OF USE IN COMBINATION WITH CAPECITABINE FOR ADVANCED OR METASTATIC BREAST CANCER WHOSE TUMORS OVEREXPRESS HER2 AND HAVE RECEIVED PRIOR THERAPY INCLUDING AN ANTHRACYCLINE, A TAXANE, AND TRASTUZUMAB (HERCEPTIN)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

TYMLOS(GHP)

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of postmenopausal osteoporosis OR male osteoporosis. Documentation that member has not previously been on a parathyroid hormone analog for greater than 2 years

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 MONTHS

OTHER CRITERIA
DOCUMENTATION OF AN ATTEMPT OF THERAPY WITH OR CONTRAINDICATION TO BISPHOSPHONATES or EITHER A PREVIOUS OSTEOPOROTIC FRACTURE OR HIGH RISK OF FRACTURE (T-SCORE LESS THAN -2.5 WITH DOCUMENTED RISK FACTORS)

TYSABRI(GHP)

MEDICATION(S)
TYSABRI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
COMBINATION THERAPY WITH IMMUNOSUPPRESSANTS (E.G. 6-MERCAPTOPURINE, AZATHIOPRINE, CYCLOSPORINE, METHOTREXATE) OR INHIBITORS OF TNF-A

REQUIRED MEDICAL INFORMATION
DX OF RELAPSING/REMITING MS (INCLUDING CLINICALLY ISOLATED SYNDROME, RELAPSING-REMITTING DISEASE, AND ACTIVE SECONDARY PROGRESSIVE DISEASE) AND DOCUMENTATION OF TYSABRI BEING USED AS MONOTHERAPY. DIAGNOSIS OF MODERATE TO SEVERE CROHN'S BASED ON CLINICAL SIGNS AND SYMPTOMS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
FOR MS: WRITTEN BY A NEUROLOGIST. FOR CROHN'S: WRITTEN BY A GASTROENTEROLOGIST

COVERAGE DURATION
CROHNS: 6 MONTHS INITIAL, 12 MONTHS CONTINUATION. MS: 12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEMBER IS ENROLLED IN A RISK-MINIMIZATION PROGRAM, CALLED THE TOUCH PRESCRIBING PROGRAM. DOCUMENTATION OF TESTING FOR ANTI-JCV ANTIBODY WITHIN THE LAST 6 MONTHS PRIOR TO START OF THERAPY AND IF ANTI-JCV ANTIBODY POSITIVE, DOCUMENTATION THAT BENEFITS OF DRUG OUTWEIGH THE RISKS OF PML AND PATIENT IS AWARE OF PML RISK. FOR RELAPSING/REMITTING MS: DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR

CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES FOR THE TREATMENT OF MS or DOCUMENTATION OF HIGHLY ACTIVE DISEASE COURSE REQUIRING AGGRESSIVE TREATMENT. FOR CROHNS: DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO OF THE FOLLOWING: HUMIRA, CIMZIA, SKYRIZI, OR FORMULARY INFLIXIMAB PRODUCT. FOR REAUTHORIZATION, MUST SHOW IMPROVEMENT IN SIGNS AND SYMPTOMS OF DISEASE AND FOR PATIENTS WHO WERE PREVIOUSLY ANTI-JCV ANTIBODY NEGATIVE, DOCUMENTATION OF RETEST YEARLY. FOR THOSE PATIENTS WHO WERE ANTI-JCV ANTIBODY POSITIVE AT BASELINE OR RETEST, DOCUMENTATION THAT BENEFITS OF CONTINUING DRUG OUTWEIGH RISKS.

TYVASO DPI(GHP)

MEDICATION(S)
TYVASO DPI INSTITUTIONAL KIT, TYVASO DPI MAINTENANCE KIT, TYVASO DPI TITRATION KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FUNCTIONAL CLASS III OR IV PULMONARY ARTERY HYPERTENSION. DIAGNOSIS OF PULMONARY HYPERTENSION ASSOCIATED WITH INTERSTITIAL LUNG DISEASE (WORLD HEALTH ORGANIZATION GROUP 3 PULMONARY HYPERTENSION).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR PAH: DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO OR USE IN COMBINATION WITH SILDENAFIL OR BOSENTAN.

TYVASO(GHP)

MEDICATION(S)
TYVASO, TYVASO REFILL, TYVASO STARTER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FUNCTIONAL CLASS III OR IV PULMONARY ARTERY HYPERTENSION. DIAGNOSIS OF PULMONARY HYPERTENSION ASSOCIATED WITH INTERSTITIAL LUNG DISEASE (WORLD HEALTH ORGANIZATION GROUP 3 PULMONARY HYPERTENSION).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR PAH: DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO OR USE IN COMBINATION WITH SILDENAFIL OR BOSENTAN

TZIELD(GHP)

MEDICATION(S)
TZIELD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF STAGE 2 TYPE 1 DIABETES (T1D) CONFIRMED BY BOTH OF THE FOLLOWING: (1) DOCUMENTATION OF AT LEAST TWO POSITIVE PANCREATIC ISLET CELL AUTOANTIBODIES AND (2) DOCUMENTATION OF DYSGLYCEMIA WITHOUT OVERT HYPERGLYCEMIA USING AN ORAL GLUCOSE TOLERANCE TEST (OGTT) [IF AN OGTT IS NOT AVAILABLE, AN ALTERNATIVE METHOD FOR DIAGNOSING DYSGLYCEMIA WITHOUT OVERT HYPERGLYCEMIA MAY BE APPROPRIATE] AND DOCUMENTATION OR PROVIDER ATTESTATION THAT THE CLINICAL HISTORY OF THE PATIENT DOES NOT SUGGEST TYPE 2 DIABETES (T2D).

AGE RESTRICTION
8 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
14 DAYS

OTHER CRITERIA
AUTHORIZATION OF TZIELD SHOULD NOT EXCEED THE FDA-APPROVED TREATMENT DURATION OF 14 DAYS. FOR REQUESTS EXCEEDING THE ABOVE LIMIT, DOCUMENTATION OF THE FOLLOWING IS REQUIRED: PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE

IMROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

UBRELVY(GHP)

MEDICATION(S)
UBRELVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of use for the acute treatment of migraine with or without aura.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to two formulary triptans (e.g., almotriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan). Documentation that medication will not be used concurrently with another CGRP antagonist indicated for the actue treatment of migraine.

UNITUXIN(GHP)

MEDICATION(S)
UNITUXIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TREATMENT OF PEDIATRIC PATIENTS WITH HIGH-RISK NEUROBLASTOMA WHO ACHIEVE AT LEAST A PARTIAL RESPONSE TO PRIOR FIRST-LINE MULTIAGENT, MULTIMODALITY THERAPY AND DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH GRANULOCYTE-MACROPHAGE COLONY-STIMULATING FACTOR (GM-CSF), INTERLEUKIN-2 (IL-2), AND 13-CIS-RETINOIC ACID (ISOTRETINOIN)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
5 MONTHS

OTHER CRITERIA
N/A

UPTRAVI IV(GHP)

MEDICATION(S)
UPTRAVI 1800 MCG RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF WHO GROUP I PULMONARY HYPERTENSION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
DOCUMENTATION OF USE IN COMBINATION WITH, OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL AND/OR AN ENDOTHELIN RECEPTOR ANTAGONIST (BOSENTAN, AMBRISENTAN OR MACITENTAN) AND DOCUMENTATION THAT REQUEST IS FOR TEMPORARY USE OF INTRAVENOUS FORMULATION AND MEMBER IS UNABLE TO TAKE ORAL UPTRAVI TABLETS. REAUTHORIZATION WILL REQUIRE DOCUMENTATION THAT REQUEST IS FOR TEMPORARY USE OF INTRAVENOUS FORMULATION AND MEMBER CONTINUES TO BE UNABLE TO TAKE ORAL UPTRAVI TABLETS.

UPTRAVI(GHP)

MEDICATION(S)
UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF WHO GROUP I PULMONARY HYPERTENSION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF USE IN COMBINATION WITH, OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL AND/OR AND ENDOTHELIN RECEPTOR ANTAGONIST (BOSENTAN, AMBRISENTAN OR MACITENTAN).

UZEDY(GHP)

MEDICATION(S)
UZEDY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF FAILURE ON OR INTOLERANCE TO ORAL EQUIVALENT OF REQUESTED INJECTABLE THERAPY.

VALCHLOR(GHP)

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF STAGE IA OR IB MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING SKIN-DIRECTED THERAPIES: TOPICAL CORTICOSTEROID, TOPICAL RETINOID, TOPICAL NITROGEN MUSTARD, OR PHOTOTHERAPY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VANDETANIB(GHP)

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MEDULLARY THYROID CANCER IN PATIENTS WITH UNRESECTABLE, LOCALLY ADVANCED, OR METASTATIC DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VANFLYTA(GHP)

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) AND DOCUMENTATION THAT MEMBER IS FLT3 INTERNAL TANDEM DUPLICATION (ITD)-POSITIVE AS DETECTED BY AN FDA-APPROVED TEST AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBINATION WITH STANDARD CYTARABINE AND ANTHRACYCLINE INDUCTION, IN COMBINATION WITH CYTARABINE CONSOLIDATION, AND AS MAINTENANCE MONOTHERAPY FOLLOWING CONSOLIDATION CHEMOTHERAPY (EXCLUDES MAINTENANCE MONOTHERAPY FOLLOWING ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. THE FDA-APPROVED TREATMENT DURATION IS UP TO 2 CYCLES OF INDUCTION, UP TO 4 CYCLES OF CONSOLIDATION, AND UP TO 36 CYCLES AS MAINTENANCE. REQUESTS BEYOND THE FDA-APPROVED TREATMENT

DURATION WILL REQUIRE DOCUMENTATION OF PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA-APPROVED TREATMENT DURATION.

VARUBI(GHP)

MEDICATION(S)
VARUBI (180 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR PREVENTION OF NAUSEA AND VOMITING ASSOCIATED WITH MODERATELY TO HIGHLY EMETOGENIC CHEMOTHERAPY REGIMENS and DOCUMENTATION THAT MEDICATION IS BEING USED IN COMBINATION WITH OTHER ANTIEMETIC AGENTS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST, ONCOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A

VECTIBIX(GHP)

MEDICATION(S)
VECTIBIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC COLORECTAL CANCER IN COMBINATION WITH FOLFOX AS FIRST LINE THERAPY OR AS MONOTHERAPY WITH DISEASE PROGRESSION ON (OR INTOLERANCE OR CONTRAINDICATION TO) FLUOROPYRIMIDINE, OXALIPLATIN, AND IRINOTECAN CONTAINING CHEMOTHERAPY REGIMENS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF WILD-TYPE RAS (DEFINED AS WILD-TYPE (NEGATIVE) IN BOTH KRAS AND NRAS) AS DETERMINED BY AN FDA-APPROVED TEST. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VELCADE(GHP)

MEDICATION(S)
BORTEZOMIB 1 MG RECON SOLN, BORTEZOMIB 2.5 MG RECON SOLN, BORTEZOMIB 3.5 MG RECON SOLN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA OR DIAGNOSIS OF MANTLE CELL LYMPHOMA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VELTASSA(GHP)

MEDICATION(S)
VELTASSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MILD TO MODERATE HYPERKALEMIA (SERUM POTASSIUM GREATER THAN OR EQUAL TO 5.1 MEQ/L AND LESS THAN 6.5 MEQ/L)

AGE RESTRICTION
MUST BE 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION THAT ATTEMPT HAS BEEN MADE TO IDENTIFY AND CORRECT THE UNDERLYING CAUSE OF THE HYPERKALEMIA OR RATIONALE AS TO WHY THE UNDERLYING CAUSE CANNOT BE CORRECTED.

VEMURAFENIB(GHP)

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E MUTATION AS DETECTED BY AN FDA APPROVED TEST. DIAGNOSIS OF ERDHEIM-CHESTER DISEASE (ECD) WITH BRAF V600 MUTATION AS DESTECTED BY AN FDA APPROVED TEST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VENCLEXTA(GHP)

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) or SMALL LYMPHOCYTIC LEUKEMIA (SLL). DOCUMENTATION OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) USED IN COMBINATION WITH AZACITIDINE, DECITABINE, OR LOW-DOSE CYTARABINE and DOCUMENTATION OF AGE GREATER THAN 75 YEARS or DOCUMENTATION OF A COMORBIDITY THAT PRECLUDES PATIENT FROM RECEIVING INTENSIVE INDUCTION CHEMOTHERAPY

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

VENTAVIS(GHP)

MEDICATION(S)
VENTAVIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR THE TREATMENT OF PRIMARY PULMONARY HYPERTENSION (WORLD HEALTH ORGANIZATION [WHO] GROUP I) IN PATIENTS WITH NEW YORK HEART ASSOCIATION (NYHA) CLASS III or CLASS IV SYMPTOMS AND DOCUMENTATION OF USE IN COMBINATION WITH, OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL AND/OR AN ENDOTHELIN RECEPTOR ANTAGONIST (BOSENTAN, AMBRISENTAN, OR MACITENTAN).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

VEOPOZ(GHP)

MEDICATION(S)
VEOPOZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CD55-DEFICIENT PROTEIN LOSING ENTEROPATHY (CHAPLE DISEASE) WITH A CONFIRMED GENOTYPE OF BIALLELIC CD55 LOSS-OF-FUNCTION MUTATION AND DOCUMENTATION THAT MEMBER IS VACCINATED WITH THE MENINGOCOCCAL VACCINE.

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST, GASTROENTEROLOGIST, OR A PROVIDER SPECIALIZING IN RARE GENETIC HEMATOLOGIC DISEASES

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT VEOPOZ WILL NOT BE USED IN COMBINATION WITH SOLIRIS (ECULIZUMAB) AND DOCUMENTATION OF A PRESCRIBED DOSE AND ADMINSTRATION THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION (I.E., IMPROVEMENT OR NO CLINICAL WORSENING OF CLINICAL SYMPTOMS, INCREASE IN OR STABILIZATION OF ALBUMIN AND IgG CONCENTRATION).

VERQUVO(GHP)

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF SYMPTOMATIC CHRONIC NEW YORK HEART ASSOCIATION CLASS II-IV HEART FAILURE, DOCUMENTATION OF A LEFT VENTRICULAR EJECTION FRACTION (LVEF) LESS THAN OR EQUAL TO 45%, AND DOCUMENTATION OF ONE OF THE FOLLOWING: HOSPITAL ADMISSION DUE TO HEART FAILURE WITHIN THE PREVIOUS 6 MONTHS OR DOCUMENTATION OF OUTPATIENT INTRAVENOUS DIURETIC TREATMENT FOR HEART FAILURE WITHIN THE PREVIOUS 3 MONTHS.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO: 1) ONE FORMULARY ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACEI), ANGIOTENSIN RECEPTOR BLOCER (ARB) OR ANGIOTENSIN RECEPTOR AND NEPRILYSIN INHIBITOR (ARNI) AND 2) ONE FORMULARY BETA-BLOCKER.

VERZENIO(GHP)

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HORMONE RECEPTOR POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 NEGATIVE (HR+/HER2-) ADVANCED OR METASTATIC BREAST CANCER WITH ONE OF THE FOLLOWING (1) ADMINISTERED WITH FULVESTRANT IN PATIENTS WHO EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR ENDOCRINE THERAPY AND DOCUMENTATION OF POSTMENOPAUSAL STATUS OR IF PRE/PERIMENOPAUSAL OR MALE, THAT THE MEMBER HAS RECEIVED A GONADOTROPIN-RELEASING HORMONE AGONIST FOR AT LEAST 4 WEEKS PRIOR TO AND WILL CONTINUE FOR THE DURATION OF VERZENIO THERAPY OR (2) USED AS MONOTHERAPY IF THE PATIENT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR ENDOCRINE THERAPY AND PRIOR CHEMOTHERAPY IN THE METASTATIC SETTING OR (3) FOR INITIAL ENDOCRINE-BASED THERAPY IN COMBINATION WITH AN AROMATASE INHIBITOR WITH DOCUMENTATION OF POSTMENOPAUSAL STATUS OR IF PRE/PERIMENOPAUSAL OR MALE, THAT THEY HAVE RECEIVED A GONADOTROPIN-RELEASING HORMONE AGONIST (I.E., LHRH AGONIST) FOR AT LEAST 4 WEEKS PRIOR TO THERAPY AND WILL CONTINUE FOR THE DURATION OF MEDICATION THERAPY and DOCUMENATION THAT MEDICATION WILL BE PRESCRIBED IN COMBINATION WITH AN AROMATASE INHIBITOR. 2)DIAGNOSIS OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, NODE-POSITIVE EARLY BREAST CANCER AND DOCUMENTATION OF A HIGH RISK OF RECURRENCE AND DOCUMENTATION THAT MEDICATION WILL BE USED AS ADJUVANT TREATMENT IN COMBINATION WITH ENDOCRINE THERAPY (SUCH AS BUT NOT LIMITED TO: TAMOXIFEN OR AN AROMATASE INHIBITOR).

AGE RESTRICTION

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
Oncologist

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR EARLY BREAST CANCER, IF BEING USED WITH AN AROMATASE INHIBITOR, DOCUMENTATION OF POSTMENOPAUSAL STATUS OR IF THE PATIENT IS PRE/PERIMENOPAUSAL OR MALE, THEY THEY HAVE RECEIVED A GONADOTROPIN-RELEASING HORMONE AGONIST FOR AT LEAST 4 WEEKS PRIOR TO AND WILL CONTINUE FOR THE DURATION OF THERAPY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REAUTHORIZATION REQUESTS FOR AJDUVANT TREATMENT OF HR-POSITIVE, HER2-NEGATIVE, NODE POSITIVE, EARLY BREAST CANCER BEYOND 2 YEARS WILL REQUIRE PEER-REVIEWED LITERATURE CITING WELL-DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBER'S HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

VIIBRYD(GHP)

MEDICATION(S)
VIIBRYD STARTER PACK, VILAZODONE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE ALTERNATIVE FROM TWO DIFFERENT CLASSES OF ANTIDEPRESSANTS (INCLUDING, BUT NOT LIMITED TO SSRI, MAOI, SNRI OR TCA).

VIJOICE(GHP)

MEDICATION(S)
VIJOICE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AND DOCUMENTATION OF MUTATION IN THE CATALYTIC ALPHA SUBUNIT OF PI3K (PIK3CA) GENE.

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF SEVERE OR LIFE-THREATENING DISEASE WHICH REQUIRES SYSTEMIC TREATMENT. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

VILTEPSO(GHP)

MEDICATION(S)
VILTEPSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DUCHENNE'S MUSCULAR DYSTROPHY (DMD) CONFIRMED BY GENETIC TESTING AND DOCUMENTATION OF A CONFIRMED MUTATION OF THE DMD GENE THAT IS AMENABLE TO EXON 53 SKIPPING. DOCUMENTATION THAT MEDICATION IS BEING GIVEN CONCURRENTLY WITH ORAL CORTICOSTEROIDS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR GENETIC SPECIALIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PATIENT DOES NOT HAVE A SYMPTOMATIC CARDIAC ABNORMALITY. DOCUMENTATION OF DOSING CONSISTENT WITH THE FDA APPROVED LABELING (MAXIMUM DOSE OF 80 MG PER KG INFUSED ONCE WEEKLY). DOCUMENTATION THAT THE PATIENT IS AMBULATORY (E.G. ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND, DOES NOT HAVE FULL-TIME DEPENDENCE ON MOTORIZED WHEELCHAIRS OR SCOOTERS FOR MOBILITY) AS PROVEN BY DOCUMENTATION OF A 6-MINUTE WALK TEST DISTANCE (6MWT) WITHIN THE PAST 3 MONTHS OF INITIATION OF MEDICATION. REAUTHORIZATION WILL REQUIRE THE FOLLOWING: DOCUMENTATION OF

CONTINUED BENEFIT FROM TREATMENT WITH VILTOLARSEN AND DOCUMENTATION OF CONCURRENT USE WITH ORAL CORTICOSTEROIDS AND DOCUMENTATION OF NO SYMPTOMATIC CARDIAC ABNORMALITY AND DOCUMENTATION OF A DOSE CONSISTENT WITH FDA APPROVED LABELING, AND DOCUMENTATION THAT PATIENT REMAINS AMBULATORY (E.G. ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND, DOES NOT HAVE FULL-TIME DEPENDENCE ON MOTORIZED WHEELCHAIRS OR SCOOTERS FOR MOBILITY) AS PROVEN BY DOCUMENTATION OF A FOLLOW-UP 6-MINUTE WALK TEST DISTANCE (6MWT) WITHIN THE PAST 6 MONTHS.

VIMPAT(GHP)

MEDICATION(S)
LACOSAMIDE 200 MG/20ML SOLUTION, VIMPAT 200 MG/20ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PARTIAL ONSET SEIZURES OR DOCUMENTTATION OF ADJUNCTIVE TREATMENT FOR PRIMARY GENERALZED TONIC-CLONIC SEIZURES

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 WEEK

OTHER CRITERIA
DOCUMENTATION OF INABILITY TO USE ORAL FORMULATION OF MEDICATION.

VITRAKVI(GHP)

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND documentation that the member must have progressed following treatment or have no satisfactory alternative treatments

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Subsequent approval after 12 months will require documentation of continued disease improvement or lack of disease progression.

VIVJOA(GHP)

MEDICATION(S)
VIVJOA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of history of recurrent vulvovaginal candidiasis (RVVC)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
RVVC is defined as 3 or more acute VVC episodes within 12 months. Documentation of one of the following: 1) that member is postmenopausal or 2) that member is 12 years of age or older AND that member is post-menarchal AND that member is not of reproductive potential (i.e., history of tubal ligation, salpingo-oophorectomy, or hysterectomy).

VIZIMPRO(GHP)

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Reauthorization will require documentation of continued disease improvement or lack of disease progression.

VONJO(GHP)

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS, INCLUDING PRIMARY MYELOFIBROSIS, POST-POLYCYTHEMIA VERA MYELOFIBROSIS OR POST-ESSENTIAL THROMBOCYTHEMIA MYELOFIBROSIS AND DOCUMENTATION OF SEVERE PLATELET THROMBOCYTOPENIA WITH A PLATELET COUNT LESS THAN OR EQUAL TO 50 X 10(9)/L AND SPLENOMEGALY AND BASELINE TOTAL SYMPTOM SCORE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION WILL NOT BE USED IN COMBINATION WITH ANOTHER JANUS KINASE INHIBITOR. CONTINUED COVERAGE EVERY 6 MONTHS WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF PLATELET COUNT LESS THAN OR EQUAL TO 50 X 10(9)/L AND DOCUMENTATION OF RESPONSE TO THERAPY SUCH AS A REDUCTION FROM PRETREATMENT BASELINE SPLEEN VOLUME OR A REDUCTION IN THE TOTAL SYMPTOM SCORE FROM BASELINE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM

ASSESSMENT FORM (MFSAF).

VORICONAZOLE(GHP)

MEDICATION(S)
VORICONAZOLE 200 MG RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of invasive aspergillosis OR documentation of treatment of candidemia in nonneutropenic patients OR documentation of disseminated candida infections in the skin, abdomen, kidney, bladder wall or wounds OR Diagnosis of esophageal candidiasis OR documentation of treatment of serious fungal infections caused by Scedosporium apiospermum and Fusarium spp., including Fusarium solani in patients intolerant of, or refratory to, other therapy.

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
N/A

VOTRIENT(GHP)

MEDICATION(S)
PAZOPANIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF ADVANCED RENAL CELL CARCINOMA WITH CLEAR CELL OR PREDOMINANTLY CLEAR CELL HISTOLOGY OR DX OF ADVANCED RENAL CELL CARCINOMA WITH NON-CLEAR CELL HISTOLOGY OR DX OF ADVANCED SOFT TISSUE SARCOMA (STS)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR DX OF ADVANCED RENAL CELL CARCINOMA WITH NON-CLEAR CELL HISTOLOGY SUBTYPE: MUST HAVE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TEMSIROLIMUS AND SUNITINIB. FOR DX OF ADVANCED SOFT TISSUE SARCOMA MUST HAVE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE PRIOR CHEMOTHERAPY TREATMENT INCLUDING BUT NOT LIMITED TO DOXORUBICIN, IFOSFAMIDE, EPIRUBICIN, GEMCITABINE, DACARBAZINE, LIPOSOMAL DOXORUBICIN, TEMOZOLOMIDE, VINORELBINE, AD REGIMEN, AIM REGIMEN, MAID REGIMEN. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

VOWST(GHP)

MEDICATION(S)
VOWST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT VOWST WILL BE USED FOR THE PREVENTION OF RECURRENCE OF C. DIFFICILE INFECTIONS AND DIAGNOSIS OF RECURRENT C. DIFFICILE INFECTION BASED ON RESULTS OF AN APPROPRIATE LABORATORY STOOL TEST WITHIN 30 DAYS OF REQUEST AND DOCUMENTATION THAT AN APPROPRIATE STANDARD OF CARE ANTIBACTERIAL REGIMEN WAS USED FOR THE TREATMENT OF RECURRENT C. DIFFICILE INFECTION (I.E., ORAL FIDAXOMICIN, ORAL VANCOMYCIN, ORAL METRONIDZOLE).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
INFECTIOUS DISEASE SPECIALIST OR GASTROENTEROLOGIST

COVERAGE DURATION
1 TREATMENT COURSE (30 DAYS)

OTHER CRITERIA
DOCUMENTATION OF A PRESCRIBED DOSE AND ADMINISTRATION THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE.

VPRIV(GHP)

MEDICATION(S)
VPRIV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TYPE 1 GAUCHER DISEASE WITH AT LEAST ONE OF THE FOLLOWING - ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTION
MUST BE 4 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
METABOLIC SPECIALIST, GENETICIST OR HEMATOLOGIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO IF PATIENT IS 18 YEARS OF AGE OR OLDER.

VRAYLAR(GHP)

MEDICATION(S)
VRAYLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA OR ACUTE TREATMENT OF MANIC OR MIXED EPISODES ASSOCIATED WITH BIPOLAR I DISORDER or documentation of use for the treatment of depressive episodes associated with bipolar I disorder (bipolar depression). DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER (MDD) AND DOCUMENTATION THAT MEDICATION IS BEING USED AS ADJUNCTIVE THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For schizophrenia or manic/mixed episodes associated with bipolar I: MEDICAL RECORD DOCUMENTATION OF TRIAL ON TWO FORMULARY ALTERNATIVES (ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, ZIPRASIDONE OR RISPERIDONE). For depressive episodes associated with bipolar I disorder (bipolar depression): medical record documentation of therapeutic failure on, intolerance to, or contraindication to quetiapine. FOR MDD: (1) DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST A 4-WEEK TRIAL OF COMBINATION THERAPY WITH ARIPIPRAZOLE AND AN ANTIDEPRESSANT AND (2)

DOCUMENTATION OF ONE OF THE FOLLOWING: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST A 4-WEEK TRIAL OF COMBINATION ANTIDEPRESSANT THERAPY (SUCH AS AN SSRI AND BUPROPION OR AN SNRI AND BUPROPION) OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST A 4-WEEK TRIAL OF AN ANTIDEPRESSANT WITH AUGMENTATION THERAPY (INCLUDING BUT NOT LIMITED TO LITHIUM, VALPROATE, CARBAMAZEPINE, OR LAMOTRIGINE).

VUITY(GHP)

MEDICATION(S)
VUITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PRESBYOPIA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
OPTOMETRIST OR OPHTHALMOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
N/A

VYEPTI(GHP)

MEDICATION(S)
VYEPTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF MIGRAINE WITH OR WITHOUT AURA AND DOCUMENTATION OF THE NUMBER OF BASELINE MIGRAINE OR HEADACHE DAYS PER MONTH.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF THE PATIENT EXPERIENCING FOUR OR MORE MIGRAINES PER MONTH. DOCUMENTATION OF A THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: AIMOVIG, EMGALITY, NURTEC. DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF BEING USED IN COMBINATION DOCUMENTATION OF THE FOLLOWING: THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND DOCUMENTATION OF A THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST. DOCUMENTATION THAT MEDICATION WILL

NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE. IF REQUEST IS FOR 300 MG EVERY 3 MONTH DOSING: DOCUMENTATION OF THERAPEUTIC FAILURE ON 100 MG EVERY 3 MONTH DOSING. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED OR SUSTAINED REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OR A DECREASE IN SEVERITY OR DURATION OF MIGRAINE AND EITHER DOCUMENTATION THE MEDICATION IS NOT BEING USED CONCURRENTLY WITH BOTULINUM TOXIN OR IF THE REQUEST IS FOR COMBINATION USE WITH BOTOX DOCUMENTATION OF THE FOLLOWING: PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 3 MONTH TRIAL OF AT LEAST ONE CGRP ANTAGONIST WITHOUT THE CONCOMITANT USE OF BOTOX AND DOCUMENTATION OF A PREVIOUS THERAPEUTIC FAILURE ON A MINIMUM 6 MONTH TRIAL OF BOTOX WITHOUT THE CONCOMITANT USE OF A CGRP ANTAGONIST. DOCUMENTATION THAT MEDICATION WILL NOT BE USED CONCOMITANTLY WITH ANOTHER CGRP ANTAGONIST INDICATED FOR THE PREVENTIVE TREATMENT OF MIGRAINE. IF REQUEST IS FOR 300 MG EVERY 3 MONTH DOSING: DOCUMENTATION OF THERAPEUTIC FAILURE ON 100 MG EVERY 3 MONTH DOSING.

VYONDYS(GHP)

MEDICATION(S)
VYONDYS 53

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DUCHENNE'S MUSCULAR DYSTROPHY (DMD) CONFIRMED BY GENETIC TESTING AND DOCUMENTATION OF A CONFIRMED MUTATION OF THE DMD GENE THAT IS AMENABLE TO EXON 53 SKIPPING. DOCUMENTATION THAT MEDICATION IS BEING GIVEN CONCURRENTLY WITH ORAL CORTICOSTEROIDS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR GENETIC SPECIALIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PATIENT HAS STABLE PULMONARY AND CARDIAC FUNCTION. DOCUMENTATION OF DOSING CONSISTENT WITH THE FDA APPROVED LABELING (MAXIMUM DOSE OF 30 MG PER KG INFUSED ONCE WEEKLY). DOCUMENTATION THAT THE PATIENT IS AMBULATORY (E.G. ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND, DOES NOT HAVE FULL-TIME DEPENDENCE ON MOTORIZED WHEELCHAIRS OR SCOOTERS FOR MOBILITY) AS PROVEN BY DOCUMENTATION OF A 6-MINUTE WALK TEST DISTANCE (6MWT) WITHIN THE PAST 3 MONTHS OF INITIATION OF MEDICATION. REAUTHORIZATION WILL REQUIRE THE FOLLOWING: DOCUMENTATION OF CONTINUED BENEFIT FROM TREATMENT

WITH GOLODIRSEN AND DOCUMENTATION OF CONCURRENT USE WITH ORAL CORTICOSTEROIDS AND DOCUMENTATION OF STABLE PULMONARY AND CARDIAC FUNCTION AND DOCUMENTATION OF A DOSE CONSISTENT WITH FDA APPROVED LABELING, AND DOCUMENTATION THAT PATIENT REMAINS AMBULATORY (E.G. ABLE TO WALK WITH ASSISTANCE, NOT WHEELCHAIR BOUND, DOES NOT HAVE FULL-TIME DEPENDENCE ON MOTORIZED WHEELCHAIRS OR SCOOTERS FOR MOBILITY) AS PROVEN BY DOCUMENTATION OF A FOLLOW-UP 6-MINUTE WALK TEST DISTANCE (6MWT) WITHIN THE PAST 6 MONTHS.

VYXEOS(GHP)

MEDICATION(S)
VYXEOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF NEWLY-DIAGNOSED THERAPY-RELATED ACUTE MYELOID LEUKEMIA (T-AML) OR AML WITH MYELODYSPLASIA-RELATED CHANGES (AML-MRC).

AGE RESTRICTION
MUST BE 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF RATIONALE WHY CYTARABINE PLUS DAUNORUBICIN (7 PLUS 3) IS NOT A MEDICALLY APPROPRIATE TREATMENT. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

WELIREG(GHP)

MEDICATION(S)
WELIREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF VON HIPPEL-LINDAU (VHL) DISEASE AND DOCUMENTATION THAT MEMBER DOES NOT REQUIRE IMMEDIATE SURGERY. DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA AND BOTH OF THE FOLLOWING: (1) DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A PD-1 INHIBITOR OR PD-L1 INHIBITOR (I.E., BAVENCIO, KEYTRUDA, OPDIVO) AND (2) DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A VEGF-TKI (I.E., CABOMETYX, FOTIVDA, INLYTA, LENVIMA, SORAFENIB, SUNITINIB, VOTRIENT).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR VHL: DISEASE CONFIRMED WITH A GERMLINE VHL ALTERANTION AND AT LEAST ONE OF THE FOLLOWING: ASSOCIATED RENAL CELL CARCINOMA (RCC) OR ASSOCIATED CENTRAL NERVOUS SYSTEM (CNS) HEMANGIOBLASTOMAS OR ASSOCIATED PANCREATIC NEUROENDOCRINE TUMORS (pNET). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

XATMEP(GHP)

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACUTE LYMPHOBLASTIC LEUKEMIA USED AS PART OF A COMBINATION CHEMOTHERAPY MAINTENANCE REGIMEN or DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS FOLLOWING AN INSUFFICIENT RESPONSE OR INTOLERANCE TO A 3 MONTH TRIAL OF A FORMULARY NSAID OR OTHER FIRST LINE THERAPY

AGE RESTRICTION
18 YEARS OF AGE OR YOUNGER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

XCOPRI(GHP)

MEDICATION(S)
XCOPRI, XCOPRI (250 MG DAILY DOSE), XCOPRI (350 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of partial onset seizures

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
by or in consultation with a neurologist

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intolerance to, or contraindication to two formulary anticonvulsant medications used to treat the same indication.

XDEMVY(GHP)

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC DEMODEX BLEPHARITIS (DB) EVIDENCED BY (1) PRESENCE OF AT LEAST MILD ERYTHEMA OF THE UPPER EYELID MARGIN AND (2) PRESENCE OF MITES UPON EXAMINATION OF EYELASHES BY LIGHT MICROSCOPY OR PRESENCE OF COLLARETTES ON SLIT LAMP EXAMINATION.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
OPHTHALMOLOGIST

COVERAGE DURATION
6 WEEKS

OTHER CRITERIA
DOCUMENTATION OF A PRESCRIBED DOSE AND ADMINSTRATION THAT IS CONSISTENT WITH FDA-APPROVED PACKAGE LABELING, NATIONALLY RECOGNIZED COMPENDIA, OR PEER-REVIEWED MEDICAL LITERATURE.

XELJANZ(GHP)

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS OR DX OF MODERATE TO SEVERE PSORIATIC ARTHRITIS WHICH MUST INCLUDE DOCUMENTATION OF EITHER ACTIVE PSORIATIC LESIONS OR A DOCUMENTED HISTORY OF PSORIASIS. DIAGNOSIS OFMODERATE TO SEVERE ULCERATIVE COLITIS. DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. DIAGNOSIS OF ANKYLOSING SPONDYLITIS.

AGE RESTRICTION
PcJIA: MUST BE 2 YEARS OR OLDER. ALL OTHER DX:18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST, DERMATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. FOR RA: DOCUMENTATION THAT MEDICATION IS BEING DOSED CONSISTENT WITH FDA-APPROVED LABELING AND THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA OR ENBREL. FOR PSA: DOCUMENTATION THAT MEDICATION IS BEING DOSED CONSISTENT

WITH FDA-APPROVED LABELING AND THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA OR ENBREL AND MEDICAL RECORD DOCUMENTATION THAT MEDICATION IS BEING PRESCRIBED IN COMBINATION WITH NON-BIOLOGIC DMARD THERAPY (INCLUDING BUT NOT LIMITED TO METHOTREXATE, SULFASALAZINE, AND/OR LEFLUNOMIDE). FOR UC: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA. FOR PCJIA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA OR ENBREL. FOR AS: THERAPEUTIC FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF ENBREL OR HUMIRA. FOR CONTINUED THERAPY: MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

XENLETA(GHP)

MEDICATION(S)
XENLETA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of community acquired bacterial pneumonia (CABP) caused by susceptible isolates of the following: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Haemophilus influenza, Legionella pneumophila, Mycoplasma pneumoniae, or Chlamydophila pneumoniae.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
1 week

OTHER CRITERIA
Documentation of culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments OR a documented history of previous intolerance to or contraindication to two other antibiotics shown to be susceptible on the culture and sensitivity OR documentation that therapy was initiated during an inpatient setting.

XENPOZYME(GHP)

MEDICATION(S)
XENPOZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DIAGNOSIS OF ACID SPHINGOMYELINASE DEFICIENCY (ASMD) AND DOCUMENTATION OF CLINICAL PRESENTATION CONSISTENT WITH ASMD TYPE B OR ASMD TYPE A/B AND DOCUMENTATION OF ONE OF THE FOLLOWING: (1) SPHINGOMYELIN PHOSPHODIESTERASE-1 (SMPD1) GENETIC MUTATION OR (2) ENZYME ASSAY DEMONSTRATING A DEFICIENCY OF ACID SPHINGOMYELINASE ACTIVITY AND DOCUMENTATION THAT XENPOZYME WILL BE USED FOR THE TREATMENT OF NON-CENTRAL NERVOUS SYSTEM MANIFESTATIONS OF ASMD.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTH INITIAL, 12 MONTH CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

XERMELO(GHP)

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of carcinoid syndrome diarrhea AND documentation that medication is being used in combination with a somatostatin analog

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation of an inadequate response on a somatostatin analog monotherapy. Reauthorization will require documentation that medication is still being used in combination with a somatostatin analog AND documentation of sustained reduction in bowel movement frequency from baseline.

XGEVA(GHP)

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF BONE METASTASES RELATED TO DISEASE PROGRESSION FROM A SOLID TUMOR (E.G. BREAST, PROSTATE, THYROID) or DOCUMENTATION OF TREATMENT OF ADULTS OR SKELETALLY MATURE ADOLESCENTS WITH GIANT CELL TUMOR OF BONE THAT IS UNRESECTABLE OR WHERE SURGICAL RESECTION IS LIKELY TO RESULT IN SEVERE MORBIDITY or DOCUMENTATION OF HYPERCALCEMIA OF MALIGNANCY THAT IS REFRACTORY TO INTRAVENOUS BISPHOSPHONATE THERAPY or DOCUMENTATION OF USE FOR THE PREVENTION OF SKELETAL RELATED EVENTS IN ADULT PATIENTS WITH MULTIPLE MYELOMA

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A

XIFAXAN(GHP)

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of traveler's diarrhea (TD) OR diagnosis of hepatic encephalopathy (HE) OR Irritable bowel syndrome with diarrhea (IBS-D).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
For TD: 3 days. for IBS-D: 14 days. For HE: remainder of contract year

OTHER CRITERIA
Documentation of a dose and duration of therapy consistent with product labeling for requested indication. For TD: documentation of a therapeutic failure on, intolerance to or contraindication to azithromycin and one oral fluoroquinolone. For HE: documentation of use concurrently with lactulose or documentation of a therapeutic failure on, intolerance to, or contraindication to lactulose. For IBS-D: documentation of a therapeutic failure on, intolerance to, or contraindication to dicyclomine and loperamide. Reauthorization for IBS-D will require documentation of having a recurrence of symptoms related to IBS-D AND documentation that member has not received more than two previous courses of this medication for the treatment of IBS-D.

XOLAIR(GHP)

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MODERATE TO SEVERE PERSISTENT ASTHMA WITH EVIDENCE OF REVERSIBLE AIRWAY DISEASE AND DOCUMENTATION OF A SPECIFIC ALLERGY REACTIVITY BY POSTIVE SKIN OR BLOOD TEST FOR A SPECIFIC IGE. DIAGNOSIS OF MODERATE TO SEVERE CHRONIC IDIOPATHIC URTICARIA AND AT LEAST 6 WEEK HISTORY OF SYMPTOMS SUCH AS HIVES ASSOCIATED WITH ITCHING OR ANGIOEDEMA. DIAGNOSIS OF ADD-ON MAINTENANCE TREATMENT OF NASAL POLYPS. DIAGNOSIS OF USE FOR THE MAINTENANCE REDUCTION OF IGE MEDIATED FOOD ALLERGIES (type 1).

AGE RESTRICTION
ASTHMA: 6 YRS OR OLDER, URTICARIA: 12 YRS OR OLDER, POLYPS: 18 YRS OR OLDER. FOOD ALLERGY: 1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTION
ASTHMA: ALLERGIST, IMMUNOLOGIST OR PULMONOLOGIST. URTICARIA: ALLERGIST, IMMUNOLOGIST, OR DERMATOLOGIST. POLYPS: BY OR IN CONSULTATION WITH ALLERGIST, PULMONOLOGIST OR OTOLARYNGOLOGIST. FOOD ALLERGY: ALLERGIST OR IMMUNOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT MEDICATION IS NOT BEING USED IN COMBINATION WITH

BENRALIZUMAB, DUPILUMAB, MEPOLIZUMAB, TEZEPELUMAB OR RESLIZUMAB. FOR ASTHMA: DOCUMENTATION THAT KNOWN ENVIRONMENTAL TRIGGERS HAVE BEEN ELIMINATED. DOCUMENTATION OF IGE LEVEL OF GREATER THAN 30 IU/ML AND LESS THAN 700 IU/ML FOR INDIVIDUALS AGE 12 AND OLDER OR IGE LEVEL OF GREATER THAN 30 IU/ML AND LESS THAN 1300 IU/ML FOR INDIVIDUALS AGE 6 THROUGH 11,DOCUMENTATION OF INADEQUATE CONTROL OR INTOLERANCE TO A 3 MONTH TRIAL OF COMBINATION PRODUCT GLUCOCORTICOID WITH LONG ACTING BETA AGONIST (SUCH AS ADVAIR, DULERA, OR BREO) AND LEUKOTRIENE RECEPTOR MODIFIER OR ANTAGONIST. FOR URTICARIA: FAILURE ON FOUR WEEK TRIAL OF MAXIMAL DOSE OF ONE ANTIHISTAMINE USED IN COMBINATION WITH EITHER A H2 RECEPTOR ANTAGONIST OR LEUKOTRIENE RECEPTOR MODIFIER OR ANTAGONIST. FOR CHRONIC IDIOPATHIC URTICARIA MUST HAVE TRIED AND FAILED 150 MG DOSE BEFORE 300 MG DOSE IS USED. FOR NASAL POLYPS: THERAPEUTIC FAILURE ON, INTOLERANCE TO , OR CONTRAINDICATION TO INTRANASAL FLUTICASONE AND MOMETASONE. FOR FOOD ALLERGY: DOCUMENTATION THAT MEDICATION WILL BE USED IN CONJUNCTION WITH A FOOD ALLERGEN-AVOIDANT DIET. DOCUMENTATION OF IGE LEVEL OF GREATER THAN 30 IU/ML. DOCUMENTATION OF A POSITIVE SKIN PRICK TEST RESPONSE TO ONE OR MORE FOODS AND DOCUMENTATION OF A POSITIVE IN VITRO TEST FOR IGE TO ONE OR MORE FOODS. PRESCRIBER ATTESTATION THAT REACTION IS SIGNIFICANT ENOUGH FOR THE MEMBER TO REQUIRE AND RECEIVE A PRESCRIPTION FOR AN EPINEPHRINE PRODUCT. DOCUMENTATION OF A DOSE CONSISTENT WITH FDA APPROVED LABELING. REAUTHORIZATION FOR ALL INDICATIONS WILL REQUIRE DOCUMENTATION OF IMPROVEMENT IN THE SIGNS AND SYMPTOMS OF DISEASE

XOSPATA(GHP)

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of relapsed or refractory acute myeloid leukemia (AML) AND documentation of a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA approved test

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Subsequent approval after 12 months will require documentation of continued disease improvement or lack of disease progression.

XPHOZAH(GHP)

MEDICATION(S)
XPHOZAH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of chronic kidney disease (CKD) on dialysis AND documentation that medication is being used as add-on therapy to control serum phosphorus levels.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
Nephrologist

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Documentation of a therapeutic failure on, intoleance to, or contraindication to calcium acetate AND either sevelamer carbonate or lanthanum carbonate

XPOVIO(GHP)

MEDICATION(S)
XPOVIO (100 MG ONCE WEEKLY), XPOVIO (40 MG ONCE WEEKLY), XPOVIO (40 MG TWICE WEEKLY), XPOVIO (60 MG ONCE WEEKLY), XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY), XPOVIO (80 MG TWICE WEEKLY)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of use in combination with dexamethasone for relapsed or refractory multiple myeloma AND documentation of previously receiving four prior regimens which include at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. Documentation of use for multiple myeloma, used in combination with bortezomib and dexamethasone following at least one prior therapy. Documentation of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma AND documentation of treatment with at least two prior lines of therapy.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

XTANDI(GHP)

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PROSTATE CANCER AND DOCUMENTATION OF ONE OF THE FOLLOWING: (1) NO LONGER RESPONDING TO CASTRATION OR HORMONE RESISTANT (CRPC) OR (2) THAT MEMBER HAS METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (mCSPC) OR (3) MEMBER HAS NONMETASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (nmCSPC) WITH BIOCHEMICAL RECURRENCE AT HIGH RISK FOR METASTASIS (HIGH-RISK BCR).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CRPC AND mCSPC: DOCUMENTATION THAT A GONADOTROPIN-RELEASING HORMONE (GnRH) ANALOG WILL BE USED CONCURRENTLY OR DOCUMENTATION OF BILATERAL ORCHIECTOMY. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

XYREM(GHP)

MEDICATION(S)
XYREM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of cataplexy in a patient with narcolepsy OR diagnosis of excessive daytime sleepiness in a patient with narcolepsy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
For excessive daytime sleepiness with narcolepsy: therapeutic failure on, intolerance to, or contraindication to modafinil AND either methylphenidate IR or amphetamine/dextroamphetamine IR. Reauthorization will require documentation of reduction in frequency of cataplexy attacks OR documentation of reduction in symptoms of excessive daytime sleepiness.

XYWAV(GHP)

MEDICATION(S)
XYWAV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CATAPLEXY IN A PATIENT WITH NARCOLEPSY OR DIAGNOSIS OF EXCESSIVE DAYTIME SLEEPINESS IN A PATIENT WITH NARCOLEPSY OR DIAGNOSIS OF IDIOPATHIC HYPERSOMNIA.

AGE RESTRICTION
FOR IDIOPATHIC HYPERSOMNIA: 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR EXCESSIVE DAYTIME SLEEPINESS WITH NARCOLEPSY: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO MODAFINIL, METHYLPHENIDATE IR OR AMPHETAMINE/DEXTROAMPHETAMINE IR AND FOR EXCESSIVE DAYTIME SLEEPINESS WITH NARCOLEPSY OR CATAPLEXY WITH NARCOLEPSY: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO XYREM OR DOCUMENTATION OF REQUIRING A LOW SODIUM ALTERNATIVE ALTERNATIVE SUCH AS DUE TO A CONCOMITANT DIAGNOSIS OF HEART FAILURE, HYPERTENSION, OR RENAL IMPAIRMENT. FOR IDIOPATHIC HYPERSOMNIA: DOCUMENTATION THAT MEMBER WAS EVALUATED AND TREATED FOR OTHER ETIOLOGIES OF EXCESSIVE DAYTIME SLEEPINESS. REAUTHORIZATION WILL

REQUIRE DOCUMENTATION OF REDUCTION IN FREQUENCY OF CATPLEXY ATTACKS OR REDUCTION IN SYMPTOMS OF EXCESSIVE DAYTIME SLEEPINESS OR IDIOPATHIC HYPERSOMNIA.

YERVOY(GHP)

MEDICATION(S)
YERVOY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF UNRESECTABLE OR METASTATIC MELANOMA WITH ONE OF THE FOLLOWING: IN COMBO W/ NIVOLUMAB FOR FIRST LINE THERAPY OR AS A SINGLE AGENT OR IN COMBO W/ NIVOLUMAB AS SECOND LINE OR SUBSEQUENT THERAPY FOR DISEASE PROGRESSION IF NOT PREVIOUSLY USED OR DOCUMENTATION OF USE AS SINGLE AGENT REINDUCTION THERAPY IN SELECT PATIENTS WHO EXPERIENCED NO SIGNIFICANT TOXICITY DURING PRIOR IPILIMUMAB THERAPY AND WHO RELAPSE AFTER INITIAL CLINICAL RESPONSE OR PROGRESS AFTER STABLE DISEASE FOR GREATER THAN 3 MONTHS OR DOCUMENTATION OF USE AS A SINGLE AGENT FOR ADJUVANT THERAPY FOR STAGE IIIA WITH METASTASES GREATER THAN 1 MM, OR STAGE IIIB OR STAGE IIIC CUTANEOUS MELANOMA WITH NODAL METASTASES FOLLOWING A COMPLETE LYMPH NODE DISSECTION OR RESECTION OR FOLLOWING COMPLETE LYMPH NODE DISSECTION OR COMPLETE RESECTION OF NODAL RECURRENCE. DX OF PREVIOUSLY UNTREATED ADVANCED RENAL CELL CARCINOMA USED IN COMBO W/ NIVOLUMAB WITH DOCUMENTATION OF INTERMEDIATE TO POOR RISK (DEFINED AS HAVING 1 OR MORE PROGNOSTIC RISK FACTORS AS PER THE IMDC CRITERIA). DX OF MICROSATELLITE INSTABILITY-HIGH (MSI-H) OR MISMATCH REPAIR DEFICIENT (DMMR) METASTATIC COLORECTAL CANCER WITH PROGRESSION FOLLOWING TREATMENT WITH A FLUOROPYRIMIDINE, OXALIPLATIN OR IRINOTECAN BASED THERAPY AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBO W/ NIVOLUMAB. DOUMENTATION OF HEPATOCELLULAR CARCINOMA USED IN COMBO W/ NIVOLUMAB. DX OF FIRST LINE METASTATIC OR RECURRENT NON SMALL CELL LUNG CANCER (NSCLC) WITH DOCUMENTION OF NO EFGR OR ALK GENOMIC TUMOR ABBERATIONS AND EITHER DOCUMENTATION OF PD-L1 GREATER THAN 1% USED IN COMBO W/ NIVOLUMAB OR

DOCUMENTATION OF USE IN COMBO W/ NIVOLUMAB AND 2 CYCLES OF PLATINUM DOUBLET CHEMOTHERAPY. DX OF UNRESECTABLE MALIGNANT PLEURAL MESOTHELIOMA AND DOCUMENTATION OF USE IN COMBO W/ NIVOLOUMAB. DX OF UNRESECTABLE ADVANCED OR METASTATIC ESOPHAGEAL SQUAMOUS CELL CARCINOMA AND DOCUMENTATION THAT MEDICATION WILL BE USED IN COMBO W/ NIVOLUMAB.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

ADJ. MELANOMA:6 MO W/12 MO REAUTH. NSCLC &MESOTHELIOMA:6 MO W/18 MO REAUTH. ALL OTHERS: 6 MO.

OTHER CRITERIA

FOR HCC: DOCUMENTATION OF A THERAPEUTIC FAILURE ON OR INTOLERANCE TO SORAFENIB. REAUTHORIZATION FOR ADJUVANT TREATMENT OF MELANOMA WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION. REAUTHORIZATION FOR OTHER INDICATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION AND DOCUMENTATION OF PEER REVIEWED LITERATURE CITING WELL DESIGNED CLINICAL TRIALS TO INDICATE THAT THE MEMBERS HEALTHCARE OUTCOME WILL BE IMPROVED BY DOSING BEYOND THE FDA APPROVED TREATMENT DURATION.

YONDELIS(GHP)

MEDICATION(S)
YONDELIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC LIPOSARCOMA OR LEIOMYOSARCOMA AND DOCUMENTATION OF PRIOR THERAPY WITH AN ANTHRACYCLINE CONTAINING REGIMEN

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SUBSEQUENT APPROVAL AFTER 12 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

YONSA(GHP)

MEDICATION(S)
YONSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of prostate cancer with evidence of metastatic disease AND member is no longer responding to castration or is hormone resistant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that methylprednisolone will be administered concomitantly with Yonsa. Reauthorization will require documentation of continued disease improvement or lack of disease progression.

ZALTRAP(GHP)

MEDICATION(S)
ZALTRAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC COLORECTAL CANCER THAT IS RESISTANT TO OR HAS PROGRESSED FOLLOWING AN OXALIPLATIN CONTAINING REGIMEN AND USE IN COMBINATION WITH IRINOTECAN OR FOLFIRI (5-FLUOROURACIL, LEUCOVORIN, IRINOTECAN)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ZAVESCA(GHP)

MEDICATION(S)
MIGLUSTAT, YARGESA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF MILD TO MODERATE TYPE 1 GAUCHER DISEASE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FOR WHOM ENZYME REPLACEMENT THERAPY IS NOT A THERAPEUTIC OPTION (I.E. BECAUSE OF CONSTRAINTS SUCH AS ALLERGY, HYPERSENSITIVITY, OR POOR VENOUS ACCESS).

ZEJULA(GHP)

MEDICATION(S)
ZEJULA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Diagnosis of recurrent epithelial ovarian, primary peritoneal, or fallopian tube cancer AND documentation the medication is being used as maintenance therapy after a complete or partial response to first-line platinum-based chemotherapy 2) diagnosis of deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, primary peritoneal,or fallopian tube cancer AND documentation the medication is being used as maintenance therapy after receiving at least 2 prior platinum-containing regimens AND documentation of a complete or partial response to the most recent platinum based TX.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Documentation that medication is being given at a dosage consistent with product labeling. Reauthorizations will require documentation of continued disease improvement or lack of disease progression.

ZEPOSIA(GHP)

MEDICATION(S)
ZEPOSIA, ZEPOSIA 7-DAY STARTER PACK, ZEPOSIA STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE SCLEROSIS. DIAGNOSIS OF MODERATE TO SEVERE ULCERATIVE COLITIS.

AGE RESTRICTION
FOR UC: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
FOR UC: GASTROENTEROLOGIST

COVERAGE DURATION
FOR UC: 12 MONTHS. FOR MS: REMAINDER OF CONTRACT YEAR.

OTHER CRITERIA
FOR UC: DOCUMENTATION THAT MEDICATION IS NOT BEING USED CONCURRENTLY WITH A TNF BLOCKER OR OTHER BIOLOGIC AGENT. THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF TWO PREFERRED BIOLOGIC AGENTS FOR UC (HUMIRA, SIMPONI, XELJANZ, RINVOQ). FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.

ZEPZELCA(GHP)

MEDICATION(S)
ZEPZELCA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC SMALL CELL LUNG CANCER (SCLC) AND DOCUMENTATION OF DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ZERBAXA(GHP)

MEDICATION(S)
ZERBAXA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of complicated intra-abdominal infection (cIAI) caused by one of the following susceptible microorganisms: Enterobacter cloacae, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, Bacteroides fragilis, Streptococcus anginosus, Streptococcus constellatus, or Streptococcus salivarius OR Diagnosis of complicated Urinary tract infection (including pyelonephritis) caused by Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis, or Pseudomonas aeruginosa OR Diagnosis of Hospital acquired bacterial pneumonia or Ventilator associated bacterial pneumonia (HABP/VABP) caused by Enterobacter cloacae, Escherichia coli, Haemophilus influenzae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, or Serratia marcescens.

AGE RESTRICTION
FOR HABP/VABP ONLY: MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
WRITTEN BY OR IN CONSULTATION WITH A INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
For UTI 1 week. For cIAI or HABP/VABP 2 weeks.

OTHER CRITERIA
Medical record documentation of a culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatements OR a documented history of previous intolerance to or contraindication to two preferred alternative formulary antibiotics shown to be susceptible on the culture

and sensitivity.

ZINPLAVA(GHP)

MEDICATION(S)
ZINPLAVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT PATIENT IS AT HIGH RISK FOR CLOSTRIDUM DIFFICILE INFECTION RECURRENCE AS EVIDENCED BY ONE OF THE FOLLOWING: ONE RISK FACTOR FOR RECURRENT DISEASE (SUCH AS BUT NOT LIMITED TO: AGE 65 OR OLDER, GREATER THAN OR EQUAL TO 10 UNFORMED STOOLS PER 24 HOURS, SERUM CREATININE GREATER THAN OR EQUAL TO 1.2 MG/DL) OR AT LEAST ONE PREVIOUS C.DIFF INFECTION WITHIN THE PAST 6 MONTHS OR HISTORY OF AT LEAST 2 PREVIOUS C.DIFF INFECTIONS EVER. DOCUMENTATION THAT MEDICATION IS BEING ADMINISTERED CONCURRENTLY WITH A STANDARD OF CARE ANTIBACTERIAL TREATMENT FOR C.DIFF (ORAL VANCOMYCIN, METRONIDAZOLE, FIDAXOMICIN). DOCUMENTATION OF ONE OF THE FOLLOWING: PATIENT DOES NOT HAVE HEART FAILURE OR RATIONALE FOR USE IN A HEART FAILURE PATIENT (THAT RISKS OUTWEIGH BENEFITS). DOCUMENTATION THAT PATIENT HAS NOT RECEIVED A PREVIOUS DOSE OF ZINPLAVA.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PRESCRIBED BY GASTROENTEROLOGIST OR WITH CONSULTATION FROM INFECTIOUS DISEASE PROVIDER

COVERAGE DURATION
ONE FILL FOR ONE DOSE

OTHER CRITERIA

N/A

ZOKINVY(GHP)

MEDICATION(S)
ZOKINVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A CONFIRMED DIAGNOSIS THROUGH GENETIC TESTING OF ONE OF THE FOLLOWING: HUTCHINSON-GILFORD PROGERIA SYNDROME OR PROCESSING DEFICIENT PROGEROID LAMINOPATHY WITH EITHER 1) HETEROZYGOUS LMNA MUTATION WITH PROGERIN-LIKE PROTEIN ACCUMULATION OR 2) HOMOZYGOUS OR COMPOUND HETEROZYGOUS ZMPSTE24 MUTATIONS.

AGE RESTRICTION
MUST BE 12 MONTHS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION OF BODY SURFATE AREA OF AT LEAST 0.39M2. DOCUMENTATION THAT THE REQUESTED DOSE IS APPROPRIATE BASED ON THE PATIENT'S BODY SURFACE AREA AND DOCUMENTATION THAT ALL POTENTIAL DRUG INTERACTIONS HAVE BEEN ADDRESSED BY THE PRESCRIBER (SUCH AS DISCONTINUATION OF THE INTERACTING DRUG, DOSE REDUCTION OF THE INTERACTING DRUG, OR COUNSELING TO THE BENEFICIARY REGARDING THE RISKS ASSOCIATED WITH THE USE OF BOTH MEDICATIONS WHEN THEY INTERACT). REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION THAT THE REQUESTED

DOSE CONTINUES TO BE APPROPRIATE BASED ON THE PATIENT'S BODY SURFACE AREA AND DOCUMENTATION THAT ALL POTENTIAL DRUG INTERACTIONS HAVE BEEN ADDRESSED BY THE PRESCRIBER (SUCH AS DISCONTINUATION OF THE INTERACTING DRUG, DOSE REDUCTION OF THE INTERACTING DRUG, OR COUNSELING TO THE BENEFICIARY REGARDING THE RISKS ASSOCIATED WITH THE USE OF BOTH MEDICATIONS WHEN THEY INTERACT).

ZONTIVITY(GHP)

MEDICATION(S)
ZONTIVITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF MYOCARDIAL INFARCTION (MI) OCCURRING LESS THAN 12 MONTHS PRIOR TO STARTING THERAPY OR DOCUMENTATION OF PERIPHERAL ARTERIAL DISEASE (PAD) AS INDICATED BY A HISTORY OF INTERMITTENT CLAUDICATION AND RESTING ANKLE/BRACHIAL INDEX (ABI) OF LESS THAN 0.85 OR AMPUTATION, PERIPHERAL BYPASS, OR PERIPHERAL ANGIOPLASTY OF THE EXTREMITIES SECONDARY TO ISCHEMIA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR MI AND PAD: DOCUMENTATION OF NO PRIOR HISTORY OF STROKE, TIA, OR ICH AND DOCUMENTATION OF CONCOMITANT THERAPY WITH ASPIRIN ALONE, A THIENOPYRIDINE (CLOPIDOGREL) ALONE, OR A COMBINATION OF ASPIRIN AND CLOPIDOGREL.

ZORBTIVE(GHP)

MEDICATION(S)
ZORBTIVE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
DOCUMENTATION OF ACUTE ILLNESS DUE TO COMPLICATIONS FROM OPEN HEART OR ABDOMINAL SURGERY, MULTIPLE ACCIDENT TRAUMA, OR ACUTE RESPIRATORY FAILURE.

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SHORT BOWEL SYNDROME and DOCUMENTATION OF CURRENT, DAILY THERAPIES WITH PARENTERAL NUTRITION (TPN OR PPN) AND/OR ENTERAL NUTRITION SUPPORT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
2 MONTHS

OTHER CRITERIA
N/A

ZORTRESS(GHP)

MEDICATION(S)
EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED KIDNEY TRANSPLANT NOT COVERED BY MEDICARE OR DOCUMENTED LIVER TRANSPLANT NOT COVERED BY MEDICARE

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PHYSICIAN EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY AND MANAGEMENT OF TRANSPLANT PATIENTS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
For kidney transplant: documentation that medication is being administered in combination with basiliximab (Simulect) induction and concurrently with reduced doses of cyclosporine and corticosteroids OR documentation of a therapeutic failure on, contraindication to or intolerance to calcineurin inhibitors. For liver transplant: documentation that medication is not being administered earlier than 30 days post transplant AND one of the following: used in combination with low dose tacrolimus and corticosteroids OR documentation of a therapeutic failure on, contraindication to or intolerance to calcineurin inhibitors.

ZORYVE(GHP)

MEDICATION(S)
ZORYVE 0.3 % CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PLAQUE PSORIASIS AND BODY SURFACE AREA LESS THAN OR EQUAL TO 20 PERCENT.

AGE RESTRICTION
6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
DERMATOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS CONTINUATION

OTHER CRITERIA
FOR MEMBERS 12 YEARS OF AGE OR OLDER: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST ONE OF THE FOLLOWING: (1) A HIGH- TO ULTRA-HIGH-POTENCY TOPICAL CORTICOSTEROID USED CONCURRENTLY WITH A GENERIC TOPICAL CALCIPOTRIENE PRODUCT OR (2) A GENERIC CALCIPOTRIENE-BETAMETHASONE PRODUCT OR (3) A HIGH- TO ULTRA-HIGH-POTENCY TOPICAL CORTICOSTEROID USED CONCURRENTLY WITH GENERIC TAZAROTENE 0.1%. FOR MEMBERS 6 TO 11 YEARS OF AGE: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MEDIUM TO HIGH-POTENCY TOPICAL CORTICOSTEROID USED CONCURRENTLY WITH A GENERIC TOPICAL CALCIPOTRIENE PRODUCT (CALCIPOTRIENE SHOULD BE AVOIDED ON THE FACE, GENITALIA, INTERTRIGINOUS AREA/FLEXURES). REAUTHORIZATION WILL REQUIRE

DOCUMENTATION OF CLINICAL IMPROVEMENT BASED ON SIGNS AND SYMPTOMS OF PLAQUE PSORIASIS.

ZTALMY(GHP)

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CDKL5 DEFICIENCY DISORDER (CDD) AND DOCUMENTATION OF GENETIC TESTING THAT CONFIRMS A CYCLIN-DEPENDENT KINASE-LIKE 5 (CDKL5) DEFICIENCY.

AGE RESTRICTION
MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 12 MONTHS CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT PATIENT IS EXPERIENCING BASELINE SEIZURES AND DOCUMENTATION OF BASELINE FREQUENCY OF SEIZURES. DOCUMENTATION OF AT LEAST TWO PREVIOUS ANTIEPILEPTIC THERAPIES. DOCUMENTATION THAT THE REQUESTED DAILY DOSE DOES NOT EXCEED THE FOLLOWING: IF WEIGHT LESS THAN OR EQUAL TO 28 KG, 63 MG PER KG PER DAY OR IF WEIGHT GREATER THAN 28 KG, 1800 MG PER DAY. REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF A SUSTAINED REDUCTION IN MONTHLY SEIZURE FREQUENCY COMPARED TO BASELINE AND DOCUMENTATION THAT THE REQUESTED DAILY DOSE DOES NOT EXCEED THE FOLLOWING: IF WEIGHT LESS THAN OR EQUAL TO 28 KG, 63 MG PER KG PER DAY OR IF WEIGHT GREATER THAN 28 KG, 1800 MG PER DAY.

ZULRESSO(GHP)

MEDICATION(S)
ZULRESSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF POSTPARTUM DEPRESSION (PPD) AS DEFINED BY 1) PATIENT EXPERIENCING A MAJOR DEPRESSIVE EPISODE AND 2) PATIENT EXPERIENCED ONSET OF SYMPTOMS WITHIN THE THIRD TRIMESTER OR WITHIN 4 WEEKS OF DELIVERY. DOCUMENTATION THAT PATIENT IS LESS THAN OR EQUAL TO 6 MONTHS POSTPARTUM AND DOCUMENTATION THAT CURRENT DEPRESSIVE EPISODE IS MODERATE TO SEVERE BASED ON A STANDARDIZED AND VALIDATED QUESTIONNAIRE/SCALE (E.G. A SCORE OF GREATER THAN 10 ON THE PATIENT HEALTH QUESTIONNAIRE (PHQ-9), A SCORE OF GREATER THAN 20 ON THE HAMILTON DEPRESSION RATING SCALE (HAM-D), ETC.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A PSYCHIATRIST

COVERAGE DURATION
ONE-TIME COURSE OF THERAPY OF 3 DAYS

OTHER CRITERIA
ADDITIONAL INFUSION(S) OF ZULRESSO FOR FUTURE CASES OF PPD ASSOCIATED WITH ADDITIONAL PREGNANCIES WILL BE REVIEWED FOR MEDICAL NECESSITY BASED ON THE ABOVE CRITERIA. MORE THAN ONE ADMINISTRATION OF ZULRESSO PER PREGNANCY/BIRTH IS CONSIDERED INVESTIGATIONAL AND NOT COVERED.

ZURZUVAE(GHP)

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF POSTPARTUM DEPRESSION (PPD) AS DEFINED BY 1) PATIENT EXPERIENCING A MAJOR DEPRESSIVE EPISODE AND 2) PATIENT EXPERIENCED ONSET OF SYMPTOMS WITHIN THE THIRD TRIMESTER OR WITHIN 4 WEEKS OF DELIVERY. DOCUMENTATION THAT PATIENT IS LESS THAN OR EQUAL TO 12 MONTHS POSTPARTUM AND DOCUMENTATION THAT CURRENT DEPRESSIVE EPISODE IS MODERATE TO SEVERE BASED ON A STANDARDIZED AND VALIDATED QUESTIONNAIRE/SCALE (E.G. A SCORE OF GREATER THAN 10 ON THE PATIENT HEALTH QUESTIONNAIRE (PHQ-9), A SCORE OF GREATER THAN 20 ON THE HAMILTON DEPRESSION RATING SCALE (HAM-D), ETC.)

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
BY OR IN CONSULTATION WITH A PSYCHIATRIST OR OBSTETRICIAN

COVERAGE DURATION
ONE-TIME COURSE OF THERAPY OF 14 DAYS

OTHER CRITERIA
ADDITIONAL COURSE(S) OF ZURANOLONE FOR FUTURE CASES OF PPD ASSOCIATED WITH ADDITIONAL PREGNANCIES WILL BE REVIEWED FOR MEDICAL NECESSITY BASED ON THE ABOVE CRITERIA. MORE THAN ONE ADMINISTRATION OF ZURANOLONE PER PREGNANCY/BIRTH IS CONSIDERED INVESTIGATIONAL AND NOT COVERED.

ZYDELIG(GHP)

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSED CHRONIC LYMPHOCYTIC LEUKEMIA (CLL).

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR CLL - DOCUMENTATION OF CONCURRENT USE WITH RITUXIMAB. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ZYKADIA(GHP)

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) THAT IS ANAPLASTIC LYMPHOMA KINASE (ALK) POSITIVE AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR ALK-POSITIVE, METASTATIC NON-SMALL CELL LUNG CANCER: DOCUMENTATION OF RATIONALE FOR NOT TREATING WITH ALECENSA IF CLINICALLY APPROPRIATE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ZYNLONTA(GHP)

MEDICATION(S)
ZYNLONTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RELAPSED OR REFRACTORY LARGE B-CELL LYMPHOMA INCLUDING DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) NOT OTHERWISE SPECIFIED, DLBCL ARISING FROM LOW GRADE LYMPHOMA, AND HIGH-GRADE B-CELL LYMPHOMA AND DOCUMENTATION OF PRIOR TREATMENT WITH TWO OR MORE LINES OF SYSTEMIC THERAPY.

AGE RESTRICTION
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL, 12 MONTHS REAUTH

OTHER CRITERIA
REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

ZYNYZ(GHP)

MEDICATION(S)
ZYNYZ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF METASTATIC OR RECURRENT LOCALLY ADVANCED MERKEL CELL CARCINOMA.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTH INITIAL, 12 MONTH CONTINUATION

OTHER CRITERIA
REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION.

ZYTIGA(GHP)

MEDICATION(S)
ABIRATERONE ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PROSTATE CANCER WITH EVIDENCE OF METASTATIC DISEASE. DOCUMENTATION OF EITHER MEMBER IS NO LONGER RESPONDING TO CASTRATION OR IS HORMONE RESISTANT or THAT THE MEMBER HAS HIGH-RISK, CASTRATION SENSITIVE DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PREDNISONE WILL BE ADMINISTERED CONCOMITANTLY WITH ABIRATERONE. REAUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION