2020 PRIOR AUTHORIZATION CRITERIA

Last Updated 07/28/2020

For the most recent list of drugs or for any other questions, please contact Providence Medicare Advantage Plans Customer Service at 503-574-8000 or 1-800-603-2340 (TTY: 711). Service is available seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). You may also visit www.ProvidenceHealthAssurance.com.
ABILIFY MYCITE

MEDICATION(S)
ABILIFY MYCITE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with a mental health provider

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Trial, failure, intolerance or contraindication to at least two injectable depot antipsychotics (e.g., Risperdal Consta, Abilify Maintena, Aristada, Aristada Initio, Invega Sustenna etc.)
ACTINIC KERATOSIS AGENTS

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL, FLUOROURACIL 0.5% CREAM, PICATO, TOLAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a dermatologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 1 month.

OTHER CRITERIA
For the treatment of actinic keratosis (AK): Documentation of trial and failure, contraindication or intolerance to the following formulary, generic topical agents: 1. Fluorouracil (2% solution or 5% cream/solution) AND 2. Imiquimod 5% cream. An adequate trial and failure is defined as failure to achieve clearance of AK lesion(s) after recommended treatment dosing and duration. Reauthorization requires documentation of a reduction in the number and/or size of lesions of AK and medical rationale for continuing therapy beyond recommended treatment course.
AEMCOLO

MEDICATION(S)
AEMCOLO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 days

OTHER CRITERIA
Diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli. Rifamycin is not covered if documentation shows diarrhea that is complicated by fever or blood in stool.
MEDICATION(S)
ALBENDAZOLE 200 MG TABLET, EMVERM

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
The following off-label uses will be covered: pinworm (Enterobius vermicularis), as an off-label use for albendazole (Albenza®).

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For diagnoses other than pinworm (Enterobius vermicularis), must be prescribed by, or in consultation with, an infectious disease specialist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for three (3) months.

OTHER CRITERIA
N/A
MEDICATION(S)
ARALAST NP, GLASSIA, PROLASTIN C, ZEMAIRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Alpha1-antitrypsin (AAT) serum concentrations. FEV1. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Documentation of serum alpha 1 antitrypsin (AAT) concentrations less than 11 uM/L (approximately 80mg/dL by immunodiffusion or 50 mg/dL by nephelometry) AND 2. Clinical evidence of emphysema as evidenced by both of the following: a. Forced expiratory volume in one second/forced vital capacity (FEV1/FVC) less than 70%. and b. FEV1 less than 80% of predicted volume.
ANTI-CANCER AGENTS

MEDICATION(S)
ABIRATERONE ACETATE, ACTIMMUNE, AFINITOR, AFINITOR DISPERZ, ALECENSA, ALUNBRIG, AYVAKIT, BALVERSA, BENDeka, BEXAROTENE, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, ERLOTINIB HCL, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FARYDAK, FASLODEX, FULVESTRANT, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, LENVIMA, LONSURF, LORBRENA, LYNPARZA, MEKINIST, MEKTOVI, NERLYNX, NEXVAR, NINLARO, NUBEQA, ODOMZO, PEMAzyRE, PIQRAY, PomALYST, REVlimid, ROZLYTREK, RUBRACA, RYDAPT, SPRYCEL, STIVARGA, SUTENT, SYLATRON, SYLATRON 4-PACK, SYNRIBO, TAFINLAR, TAGRISO, TALZENNA, TARGRETIN 1% GEL, TASIGNA, TAZVERIK, TIBSOVO, TRETINOIn 10 MG CAPSULE, TUKYSA, TURALIO, TYKERB, VENCLEXTA, VENCLEXtA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, XALKORI, XOSPATA, XPOVIO 100 MG ONCE WEEKLY DOSE, XPOVIO 60 MG ONCE WEEKLY DOSE, XPOVIO 80 MG ONCE WEEKLY DOSE, XPOVIO 80 MG TWICE WEEKLY DOSE, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, ZYTIGA 500 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist, transplant specialist, or neurologist.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Indications supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher.
ANTIEPILEPTIC AGENTS

MEDICATION(S)
APTIOM, BANZEL, FYCOMPA 0.5 MG/ML ORAL SUSP, FYCOMPA 10 MG TABLET, FYCOMPA 12 MG TABLET, FYCOMPA 2 MG TABLET, FYCOMPA 4 MG TABLET, FYCOMPA 6 MG TABLET, FYCOMPA 8 MG TABLET, VIGABATRIN, VIGADRONE, VIMPAT 10 MG/ML SOLUTION, VIMPAT 100 MG TABLET, VIMPAT 150 MG TABLET, VIMPAT 200 MG TABLET, VIMPAT 200 MG/20 ML VIAL, VIMPAT 50 MG TABLET, XCOPRI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with a neurologist.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Documentation of trial and failure, intolerance, or contraindication to at least two formulary, generic, antiepileptic medications.
ANTIFUNGAL AGENTS

MEDICATION(S)
CRESEMBA 186 MG CAPSULE, ITRACONAZOLE 10 MG/ML SOLUTION, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, ONMEL, POSACONAZOLE, VORICONAZOLE 200 MG TABLET, VORICONAZOLE 200 MG VIAL, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an infectious disease specialist, hematologist, oncologist, dermatologist or pulmonologist

COVERAGE DURATION
Aspergillus/Candida infection prophylaxis: initial/reauth 1 yr. Other uses: initial 3 mo/reauth 1 yr

OTHER CRITERIA
Must meet criteria for following indications: 1. For oropharyngeal or esophageal candidiasis: only itraconazole solution (Sporanox), posaconazole and voriconazole may be covered if the following criteria are met: Documented failure, intolerance, or contraindication to fluconazole, 2. For the treatment of invasive Aspergillus or Candida infections: a. voriconazole may be covered, b. For posaconazole or isavuconazonium: Documented failure, intolerance, or contraindication to voriconazole, 3. For the treatment of blastomycosis or histoplasmosis: only voriconazole may be covered with documented failure, intolerance, or contraindication to generic itraconazole capsules, 4. For prophylaxis of invasive Aspergillus or Candida
infections: only posaconazole may be covered if the patient is immunocompromised due to one of the following:  a. Hematopoietic stem cell transplant recipients with graft-versus-host disease, b. Current diagnosis of cancer currently undergoing chemotherapy or radiation, c. HIV/AIDS, 5. For treatment of mucormycosis: isavuconazonium may be covered.
**ANTIPSYCHOTICS**

**MEDICATION(S)**
CAPLYTA, LATUDA, REXULTI, SAPHRIS, SECUADO, VRAYLAR

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Authorization will be approved until no longer eligible with the plan.

**OTHER CRITERIA**
For adjunctive treatment of major depressive disorder (brexipiprazole only): 1. Documentation of current use of an antidepressant (e.g., citalopram, sertraline, paroxetine, duloxetine, mirtazapine, venlafaxine) AND 2. Documented trial, failure, intolerance or contraindication to quetiapine and aripiprazole. For schizophrenia or bipolar disorder: Documented trial, failure, intolerance or contraindication to two formulary, generic antipsychotics (e.g., quetiapine, olanzapine, ziprasidone, risperidone, aripiprazole).
MEDICATION(S)
APOKYN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with 5HT3 receptor antagonists (e.g., ondansetron, granisetron, dolasetron, or palonosetron)

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one (1) year.

OTHER CRITERIA
1. Patient has advanced Parkinson’s disease and is experiencing acute intermittent hypomobility (“off” episodes) lasting at least 2 hours AND 2. Patient is on other medications for the treatment of Parkinson’s disease (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.)
MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 12 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
For Cryopyrin-Associated Periodic Syndrome (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS): Diagnosis confirmed by: 1. Laboratory evidence of genetic mutation NLRP-3 (Nucleotide-binding domain, leucine rich family pyrin domain containing 3) or CIAS1 (Cold-induced auto-inflammatory syndrome-1), AND 2. Classic symptoms associated with FCAS or MWS (e.g., recurrent intermittent fever and rash typically associated with natural or artificial cold). Reauthorization requires documentation of improvement of symptoms, such as fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis.
BENIGN PROSTATIC HYPERTROPHY

MEDICATION(S)
CIALIS 2.5 MG TABLET, CIALIS 5 MG TABLET, TADALAFIL 2.5 MG TABLET, TADALAFIL 5 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Use for sexual dysfunction without comorbid diagnosis of benign prostatic hypertrophy (BPH)

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
For signs and symptoms of benign prostatic hyperplasia (BPH): Documentation of an adequate trial and failure, intolerance, or contraindication to at least one formulary drug from EACH of the following medication categories: 1. Alpha-adrenergic blockers (e.g. tamsulosin, doxazosin, terazosin, alfuzosin) AND 2. 5-alpha reductase inhibitor (e.g. finasteride or dutasteride). For brand name medications (e.g., Cialis): Documentation of medical rationale for using a branded medication over the equivalent generic medication.
BENLYSTA

MEDICATION(S)
BENLYSTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Severe active lupus nephritis (presence of proteinuria greater than or equal to 3.5gm/day), 2. Severe active Central Nervous System Lupus, 3. Current use of other biologic immunomodulator, OR 4. Current use of IV cyclophosphamide

REQUIRED MEDICAL INFORMATION
Antinuclear antibody (ANA) or anti-dsDNA. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a rheumatologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For systemic lupus erythematosus (SLE): 1. Documentation that patient is auto-antibody positive, defined as either: a. Antinuclear antibody (ANA) positive, defined as: i. Titer greater than or equal to 1:80 by immunofluorescence assay (IFA) OR ii. Definite and consistent positive result report by ELISA ANA greater than upper limit of normal as defined by laboratory: OR b. Anti-double-stranded DNA (anti-dsDNA) positive (concentration greater than or equal to 30 IU/ml). AND 2. Documentation that patient requires daily use of oral corticosteroids unless contraindicated or not tolerated. AND 3. Documented trial and failure of, contraindication to, or intolerance to an adequate treatment course with at least one of the following: azathioprine, methotrexate, mycophenolate moefitil, hydroxychloroquine, chloroquine, cyclophosphamide. Reauthorization requires: 1. Documentation of successful response to the medication AND 2.
Documentation that oral corticosteroid use is stable or decreased.
BRAND OVER GENERIC

MEDICATION(S)
EXJADE, NASONEX, PROAIR HFA, PROVENTIL HFA, RANEXA, RAPAFLO, VENTOLIN HFA, VESICARE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Coverage may be approved if a supporting statement from the provider outlines medical rationale for the use of the brand formulation over the generic formulation.
BRIVIACT/SPRITAM

MEDICATION(S)
BRIVIACT, SPRITAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Documentation of trial and failure, contraindication or intolerance to generic levetiracetam tablets or oral solution.
MEDICATION(S)
BUDESONIDE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 8 weeks.

OTHER CRITERIA
All the following criteria must be met: 1. Documentation of active ulcerative colitis, 2. Trial and failure, intolerance, or contraindication to generic mesalamine delayed-release tablets, 3. For patients with distal ulcerative colitis, proctosigmoiditis or proctitis: trial and failure, intolerance, or contraindication to mesalamine enema or suppositories. The initial approval will allow for an 8-week treatment course to induce remission. Further approval requires medical rationale why standard maintenance therapy with generic budesonide delayed-release capsules or other medication for ulcerative colitis is not appropriate.
MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 90 days.

OTHER CRITERIA
Initial Criteria: 1. Diagnosis of acquired thrombotic thrombocytopenic purpura 2. Documentation that therapy will be given in combination with plasma exchange therapy 3. Documentation that therapy will be given in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab) Reauthorization criteria: If the request is for a new treatment cycle: 1. Documentation of previous positive response to therapy (such as an improvement in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers) 2. Documentation that therapy will be given in combination with plasma exchange therapy and immunosuppressive therapy (i.e., glucocorticoids, rituximab) 3. Documentation that length of therapy post plasma exchange will not exceed 58 days 4. Documentation that patient has not had more than two recurrences of acquired thrombotic thrombocytopenic purpura while on therapy with caplacizumab. Recurrence is defined as initial platelet normalization followed by a reduction in platelet count that necessitates re-initiation of plasma exchange. If request is for treatment extension: 1. Documentation of
positive response to therapy (such as an improvement in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers) 2. Documentation that patient has signs of persistent underlying disease such as persistent severe ADAMTS13 deficiency 3. Documentation that length of therapy post plasma exchange will not exceed 58 days
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONISTS FOR MIGRAINE PROPHYLAXIS

MEDICATION(S)
AIMOVIG AUTOINJECTOR, AIMOVIG AUTOINJECTOR (2 PACK), EMGALITY PEN, EMGALITY SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another calcitonin gene-related peptide (CGRP) agent

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial approval will be for 1 year. Reauth will be approved until no longer eligible with the plan

OTHER CRITERIA
Initial authorization for migraine prophylaxis (Aimovig and Emgality): 1. Diagnosis of migraine headaches with at least four (4) headache days per month. 2. One of the following: a. Trial and failure of at least one conventional migraine prophylaxis medication [e.g., anticonvulsants (divalproex, topiramate), beta-blockers (propranolol)] b. Documented intolerance or contraindication to a conventional migraine prophylaxis medication 3. Documentation that if the patient is currently receiving CGRP therapy, treatment with the other CGRP will be discontinued. Initial authorization for cluster headache prophylaxis (Emgality only): 1. Diagnosis of episodic cluster headaches and both of the following: a. A history of at least five (5) cluster headache attacks with at least two of the cluster periods lasting at least 7 days b. Cluster periods are separated by at least three (3) months of pain-free remission. Reauthorization for all indications:
Documented reduction in the severity or frequency of headaches.
MEDICATION(S)
KALYDECO, ORKAMBI, SYMDEKO, TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FDA-cleared Cystic Fibrosis mutation test results. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a pulmonologist or provider at a Cystic Fibrosis Center.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. Diagnosis of cystic fibrosis (CF) with documentation of a cystic fibrosis transmembrane regulator (CFTR) gene mutation that is responsive to the requested drug (as indicated in FDA package labeling) through an FDA-cleared CF mutation test. Reauthorization requires documented response to therapy as defined by one of the following: 1. A lack of decline in lung function as measured by FEV1 when the patient is clinically stable, 2. A reduction in the incidence of pulmonary exacerbations, or 3. An improvement in BMI from baseline
MEDICATION(S)
CHENODAL

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Cerebrotendinous xanthomatosis.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For cerebrotendinous xanthomatosis, must be prescribed by, or in consultation with, a genetics or metabolism specialist. For gallstone dissolution, must be prescribed by a gastroenterologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For cerebrotendinous xanthomatosis: documentation of confirmed diagnosis (e.g. clinical presentation and/or genetic testing). Reauthorization will require documentation of positive response to therapy. For gallstone dissolution all of the following must be met: 1. Documentation that the patient is not a candidate for surgical removal of gallstones, 2. Documentation of trial and failure, contraindication or intolerance to ursodiol. For reauthorization: Documentation that total duration of therapy has not exceeded two years
MEDICATION(S)
CHOLBAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient weight, dose and frequency of administration being requested, and baseline liver function tests (AST, ALT, GGT, ALP, total bilirubin, INR). For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a medical geneticist, pediatric gastroenterologist, hepatologist or other specialist experienced in treating inborn errors of metabolism.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For bile acid synthesis disorder: Documentation of a single enzyme defect. For peroxisomal disorder: 1. Documentation of manifestations of at least one of the following: a. Liver disease (e.g., jaundice, elevated serum transaminases), b. Steatorrhea, c. Complications from decreased fat-soluble vitamin absorption (e.g., poor growth): AND 2. Documentation that the medication will be used as adjunctive therapy. Reauthorization requires documentation of positive clinical response to therapy.
MEDICATION(S)
CINRYZE, HAEGARDA, TAKHZYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Combination prophylaxis therapy with Cinryze, Haegarda, or Takhzyro

REQUIRED MEDICAL INFORMATION
Complement component C4 and C1-inhibitor quantitative OR C1-inhibitor functional. Current patient weight. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an immunologist or allergist.

COVERAGE DURATION
Initial prior authorization will be approved for 3 months. Reauthorization may be approved for 1 yr.

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Hereditary Angioedema (HAE) Type I, II or III, 2. Documentation of one of the following clinical criteria: a. Self-limiting, noninflammatory subcutaneous angioedema without urticaria, recurrent, and lasting more than 12 hours, b. Self-remitting abdominal pain without clear organic etiology, recurrent, and lasting more than six hours, or c. Recurrent laryngeal edema, 3. Documentation of greater than or equal to 2 HAE attacks per month on average for the past 3 months despite removal of triggers (eg. estrogen containing oral contraceptive, angiotensin converting enzyme inhibitors) unless medically necessary, 4. Trial and failure, intolerance or contraindication to long-term prophylaxis with androgen therapy, such as danazol, stanozolol or oxandrolone, unless not indicated (eg. pregnancy, lactation, pre-pubescent children), 5. One of the following: a. For HAE Type I and Type II, documentation of at least two (2) complement studies taken at least one month apart with the patient in
their basal condition and after the first year of life that show: i. C4 is less than 50 percent of the lower limit of normal AND ii. One of the following: 1. C1-inhibitor (C1-INH) protein is less than 50 percent of the lower limit of normal, or 2. C1-INH function is less than 50 percent of the lower limit of normal, b. For HAE with normal C1-INH or HAE Type III: i. Confirmed Factor 12 (FXII) mutation OR ii. Positive family history for HAE AND attacks lack response with high dose antihistamines or corticosteroids. For coverage of Cinryze: Documentation of trial and failure or contraindication to Haegarda. Dosing regimens beyond quantity limits will only be approved if evidence-based-rationale is provided. Reauthorization: Documentation must be provided showing benefit of therapy with reduction of frequency and severity of HAE attacks.
**CORLANOR**

**MEDICATION(S)**
CORLANOR

**PA INDICATION INDICATOR**
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

**OFF LABEL USES**
Inappropriate sinus tachycardia.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, a cardiologist or electrophysiologist.

**COVERAGE DURATION**
Authorization will be approved until no longer eligible with the plan.

**OTHER CRITERIA**
For chronic heart failure, all of the following must be met: 1. Symptoms consistent with New York Heart Association (NYHA) Class II, III, or IV, 2. Left-ventricular ejection fraction of 35% or less for adults or 45% or less for pediatric patients, 3. Documentation that patient is currently in normal sinus rhythm with resting heart rate as follows: age 6-12 months: at least 105 bpm, age 1-3 years: at least 95 bpm, age 3-5 years: at least 75 bpm, age over 5 years: at least 70 bpm, 4. Concurrent use of maximally tolerated dose of a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) or contraindication to their use, 5. Documentation of trial and failure, contraindication, or intolerance to maximally tolerated dose of an ACE inhibitor (e.g., lisinopril, enalapril) or ARB (e.g., losartan, valsartan), AND 6. For adults: documentation that the patient has been hospitalized for worsening heart failure in the previous 12 months. For inappropriate sinus tachycardia, all of the following must be met: 1. Documentation of a sinus heart rate of greater than 100 bpm at rest (with a mean 24-hour heart rate greater than 90 bpm), 2. Documentation that other causes of
sinus tachycardia have been ruled out (e.g., thyroid disease, medications or drugs)
MEDICATION(S)
DALIRESP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Asthma without COPD, Moderate-severe hepatic impairment (Child Pugh B or C)

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a pulmonologist

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
All of the following criteria must be met: 1. A confirmed diagnosis of severe (stage III) or very severe (stage IV) chronic obstructive pulmonary disease (COPD) with forced expiratory volume in one second (FEV1) less than 50% of predicted associated, 2. Diagnosis associated with chronic bronchitis, defined as a daily cough with production of sputum for 3 months, two years in a row, 3. An adequate trial and failure, contraindication or intolerance to maintenance treatment with triple therapy: long-acting beta-2 agonist (LABA)/long-acting antimuscarinic agonists (LAMA)/inhaled corticosteroid (ICS)
DOPTELET

MEDICATION(S)
DOPTELET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist hematologist, gastroenterologist or liver specialist

COVERAGE DURATION
For CLD for 1 month (15 tabs). For ITP initial auth for 3 months, reauth for 1 year

OTHER CRITERIA
For Treatment of Thrombocytopenia in Patients with Chronic Liver Disease (CLD): 1. Diagnosis of chronic liver disease 2. Platelet count of less than 50,000 platelets/uL 3. Documentation that patient will have a scheduled medical or dental procedure within the next 30 days and therapy will be started 10-13 days prior to the procedure. For chronic immune thrombocytopenia (ITP): 1. Platelet count of less than 30,000 platelets/uL 2. Inadequate response to at least TWO of the following therapies: a. Corticosteroids b. Immunoglobulins c. Splenectomy d. Rituximab. Reauthorization: Documentation of a positive response to therapy, such as an increase in platelet count.
DPP-4 INHIBITORS

MEDICATION(S)
ALOGLIPTIN, ALOGLIPTIN-METFORMIN, ALOGLIPTIN-PIOGLITAZONE, GLYXAMBI, JANUMET, JANUMET XR, JANUVIA, JENTADUETO, JENTADUETO XR, KOMBIGLYZE XR, ONGLYZA, STEGLUJAN, TRADJENTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HbA1c. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial auth approved for 1 yr. Reauth will be approved until no longer eligible with the plan.

OTHER CRITERIA
All the following criteria must be met: 1. Documentation of trial and failure, contraindication or intolerance to metformin therapy, at the maximum effective dose of 2000 mg/day AND 2. Documented trial and failure to one of the following medications classes, or intolerance/contraindication to all classes listed below: a. Sulfonylurea (e.g., glimepiride), b. Thiazolidinedione (e.g., pioglitazone), c. Sodium-glucose co-transporter-2 (SGLT2) inhibitor [e.g., empagliflozin (Jardiance®)], d. Glucagon-like peptide-1 (GLP-1) receptor agonist (e.g., liraglutide, exenatide, semaglutide). AND 3. A documented HbA1c, obtained within the last six months, that is greater than or equal to 7% and less than or equal to 10%. Reauthorization requires documentation that HbA1c remains less than or equal to 9% (taken within previous 6 months).
DRONABINOL

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
For nausea and vomiting associated with cancer chemotherapy: 1. Documentation of trial and failure, contraindication or intolerance to a 5HT-3 receptor antagonist (e.g., ondansetron). AND 2. Documentation of trial and failure, contraindication or intolerance to one of the following formulary medications unless contraindicated: promethazine, prochlorperazine, chlorpromazine, or metoclopramide. For anorexia with weight loss in patients with AIDS: 1. Documentation that patient is currently taking anti-retroviral therapy AND 2. If patient is less than 65 years of age: Documentation of trial and failure, contraindication, or intolerance to megestrol (Megace)
MEDICATION(S)
DUPIXENT SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Moderate-to-severe atopic dermatitis: Use in combination with other therapeutic immunomodulators used for the treatment of skin disorders (e.g., Xolair®, Taltz®). Eosinophilic and corticosteroid dependent asthma: Use in combination with other anti-asthma monoclonal antibodies, such as mepolizumab (Nucala®), benralizumab (Fasenra®), reslizumab (Cinqair®), and omalizumab (Xolair®) for any indication.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. Eosinophilic and corticosteroid dependent asthma: Absolute Eosinophil Count, and Asthma Control Test (ACT) or Asthma Control Questionnaire (ACQ) score

AGE RESTRICTION
Approved for patients 12 years of age and older

PRESCRIBER RESTRICTION
Moderate-to-severe atopic dermatitis: Must be prescribed by, or in consultation with, a dermatologist, allergist or immunologist. Eosinophilic and corticosteroid dependent asthma: Must be prescribed by, or in consultation with an asthma specialist (such as a pulmonologist, immunologist, or allergist). Chronic rhinosinusitis with nasal polyposis: Must be prescribed by, or in consultation with, an otolaryngologist, allergist, or pulmonologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For moderate-to-severe atopic dermatitis: 1) Diagnosis of chronic moderate to severe atopic dermatitis despite the use of therapies outlined in criterion number 2 and 3 below. 2) Documented trial and failure of a topical high-potency topical corticosteroid (e.g., clobetasol 0.05%) applied once daily for at least two (2) weeks or a topical calcineurin inhibitor (e.g., tacrolimus ointment) applied twice daily for at least one (1) month. 3) Documented trial and failure of an adequate treatment course with a systemic immunomodulatory agents (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate) for at least two (2) months unless contraindicated. Reauthorization requires documentation of reduction from baseline of flares, pruritus, and affected BSA. For eosinophilic asthma or oral corticosteroid dependent asthma: 1) Documentation of one of the following: a. A blood eosinophil count of at least 150 cells/microliter in the past 3 months b. A blood eosinophil count of at least 300 cells/microliter in the past 12 months c. Past history of eosinophilic asthma if currently on daily maintenance treatment with oral glucocorticoids d. Documentation of oral corticosteroid dependent asthma. 2) Documentation of a trial/failure of a combination of a high-dose inhaled corticosteroid and a long-acting inhaled beta2-agonist unless there is intolerance or contraindication to the medications. 3) Documentation of inadequate asthma control such as frequent exacerbations or hospitalizations. Reauthorization requires documentation of response to therapy, such as attainment and maintenance of remission or decrease in number of relapses. For Adjunct Therapy for Chronic Rhinosinusitis with Nasal Polyp (CRSwNP): 1) Evidence of nasal polyposis by direct examination, endoscopy or sinus CT scan. 2) Documentation of an inadequate response to, or has an intolerance or contraindication to, oral systemic corticosteroids. 3) Patient has tried and had an inadequate response to a 3-month trial of intranasal corticosteroids (e.g., fluticasone) or has a documented intolerance or contraindication to ALL intranasal corticosteroids. 4) Documentation that patient will continue standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with dupilumab. Reauthorization for CRSwNP: Documentation of positive clinical response to therapy such as symptom improvement.
MEDICATION(S)
EGRIFTA, EGRIFTA SV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Waist circumference, waist-to-hip ratio, body mass index (BMI), and fasting blood glucose (FBG). For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For HIV-associated lipodystrophy, all of the following criteria must be met: 1. Documentation of patient’s waist circumference: a. Waist circumference greater than or equal to 37.4 inches (95 cm) for males OR b. Waist circumference greater than or equal to 37 inches (94 cm) for females, 2. Documentation of waist-to-hip ratio: a. Waist-to-hip ratio greater than or equal to 0.94 for males OR b. Waist-to-hip ratio greater than or equal to 0.88 for females, 3. Documentation of a body mass index (BMI) of greater than 20 kg/meter squared, 4. Documentation of fasting blood glucose (FBG) of less than or equal to 150 mg/dL (8.33 mmol/L), AND 5. Documentation that patient has been on a stable regimen of antiretrovirals for at least 8 weeks. Reauthorization will require documentation of clinical improvement (e.g., decrease in waist circumference, improvement in visceral adipose tissue).
MEDICATION(S)
EMFLAZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient’s weight. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 2 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a provider that specializes in the treatment of Duchenne muscular dystrophy (DMD) and/or neuromuscular disorders.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one (1) year.

OTHER CRITERIA
For Duchenne Muscular Dystrophy, all of the following criteria must be met: 1. The patient has tried both prednisone daily and prednisone weekend regimen and experienced unmanageable and clinically significant weight gain/obesity or psychiatric/behavioral issues (e.g., abnormal behavior, aggression, irritability), 2. The dose requested is within FDA labeled dosing based on the patient’s weight (patient’s weight must be provided), AND 3. Dose is given in most cost effective manner (e.g., rounding to appropriate tablet strength or use of suspension) Reauthorization requires all of the following criteria to be met: 1. Documentation of clinical benefit from therapy, such as improvement or stabilization of muscle strength or pulmonary function, 2. The dose requested is within FDA labeled dosing based on the patient’s weight (updated weight must be provided), AND 3. Dose is given in most cost effective manner (e.g., rounding to appropriate tablet strength or use of suspension)
ENZYME REPLACEMENT THERAPY

MEDICATION(S)
ALDURAZYME, CEREZYME, ELAPRASE, ELELYSO, FABRAZYME, KANUMA, LUMIZYME, NAGLAZYME, VIMIZIM, VPRIV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary. Current patient weight.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with a hepatologist, endocrinologist, medical geneticist, cardiologist, pulmonologist, or bone and mineral specialist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
Initial authorization requires documentation of an enzyme assay or genetic testing that confirms the diagnosis. Initial dose approval will be based on patient’s current weight. Increases in dose will require new authorization with patient’s weight and relevant chart notes.
MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Liver function test and patient weight. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescriber by, or in consultation with, an epilepsy specialist or pediatric neurologist.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Initial authorization: 1. Documentation that patient has one of the following: a. Seizures associated with Lennox-Gastaut syndrome (LGS) OR b. Seizures associated with Dravet syndrome (DS) AND 2. Documented trial, failure, intolerance or contraindication to clobazam AND 3. Documented trial, failure, intolerance or contraindication to one additional of the following: valproate /valproic acid, lamotrigine, levetiracetam, topiramate, felbamate, zonisamide AND 4. Documentation that it will be used as adjunctive therapy with other antiepileptic drugs AND 5. Baseline liver function tests must be documented AND 6. Dose will not exceed 20 mg/kg/day. Reauthorization requires: 1. Documentation of recent liver function test AND 2. Documentation of positive response to therapy such as a decrease in seizure frequency or intensity since beginning therapy AND 3. Dose continues to not exceed 20 mg/kg/day
MEDICATION(S)
ESBRIET, OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
High-resolution computed tomography. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a pulmonologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For Idiopathic Pulmonary Fibrosis: 1. Confirmed diagnosis of Idiopathic Pulmonary Fibrosis AND 2. Presence of a histological pattern associated with usual interstitial pneumonia (UIP) on high-resolution computed tomography (HRCT) or lung biopsy. For Systemic Sclerosis-associated Interstitial Lung Disease (SScILD) (nintedanib only): 1. Confirmed diagnosis of systemic sclerosis AND 2. Presence of fibrosis associated with interstitial lung disease confirmed by HRCT. For chronic fibrosing interstitial lung diseases (ILD) with a progressive phenotype (nintedanib only): 1. Presence of ILD confirmed by evidence of pulmonary fibrosis on HRCT AND 2. Documentation of clinical evidence of progressive disease such as: decline in forced vital capacity (FVC) of at least 10% of predicted value (as reported by spirometry performed on two different dates within the last two years), an increased extent of fibrosis from previous on HRCT, or worsening respiratory symptoms and increased extent of fibrosis on chest imaging (e.g., X-ray)
MEDICATION(S)
EXTAVIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, contraindication, or intolerance to two (2) of the following: interferon-beta 1a (Avonex, Rebif or Plegridy), interferon-beta 1b (Betaseron), dimethyl fumarate (Tecfidera), glatiramer acetate (Copaxone), teriflunomide (Aubagio) or fingolimod (Gilenya).
MEDICATION(S)
FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 12 years of age and older

PRESCRIBER RESTRICTION
For eosinophilic asthma: must be prescribed by or in consultation with an asthma specialist (such as a Pulmonologist, Immunologist, or Allergist)

COVERAGE DURATION
Initial authorization will be approved for 6 months, reauthorization will be approved for 1 year

OTHER CRITERIA
For eosinophilic asthma: 1) Documentation of one of the following: a. A blood eosinophil count of at least 150 cells/microliter in the past 3 months b. A blood eosinophil count of at least 300 cells/microliter in the past 12 months c. Past history of eosinophilic asthma if currently on daily maintenance treatment with oral glucocorticoids 2) Documentation of a trial/failure of a combination of a high-dose inhaled corticosteroid and a long-acting inhaled beta2-agonist unless there is intolerance or contraindication to the medications 3) Documentation of severe asthma with inadequate control such as frequent exacerbations requiring oral corticosteroids or hospitalizations or a poor asthma control scores (An ACT score less than 20 or an ACQ greater than 1.5) Reauthorization: Documentation of response to therapy such as an improvement in baseline asthma control scores, reduction in exacerbations/hospitalizations or oral corticosteroids
FENTANYL CITRATE

MEDICATION(S)
FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG, LAZANDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of all the following: 1. Treatment of breakthrough cancer pain (prescriber MUST submit chart notes or other documentation supporting a diagnosis of cancer related pain), 2. Failure of or intolerance to at least two other oral or parenteral short-acting narcotic formulary agents, 3. Pain is not controlled with long-acting narcotic analgesics, AND 4. For fentanyl nasal spray: documentation of trial and failure, or intolerance to fentanyl citrate lozenge/troche. Reauthorization requires documentation that patient continues to have breakthrough cancer pain (prescriber MUST submit recent chart notes or other documentation supporting a diagnosis of cancer related pain AND list type of cancer)
MEDICATION(S)
ICATIBANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Complement component C4 and C1-inhibitor quantitative OR C1-inhibitor functional. Current patient weight. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an immunologist or allergist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Hereditary Angioedema (HAE) Type I, II or III, 2. One of the following clinical criteria: a. Self-limiting, recurrent, non-inflammatory subcutaneous angioedema without urticaria lasting more than 12 hours, b. Self-remitting, recurrent abdominal pain without clear organic etiology lasting more than six hours, or c. Recurrent laryngeal edema, 3. One of the following: a. For HAE Type I and Type II, documentation of at least two (2) complement studies (taken at least one month apart with the patient in their basal condition and after the first year of life) that show: i. C4 less than 50 percent of the lower limit of normal AND ii. One of the following: 1. C1-Inhibitor (C1-INH) protein less than 50 percent of the lower limit of normal or 2. C1-INH function is less than 50 percent of the lower limit of normal: b. For HAE with normal C1-INH or HAE Type III, one of the following: i. Confirmed Factor 12 (FXII) mutation OR ii. Positive family history for HAE AND attacks that lack response with high dose antihistamines or
corticosteroids.
MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Repetitive Nerve Stimulation (RNS) or anti-P/Q type voltage-gated calcium channel antibody test. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist

COVERAGE DURATION
Initial approval will be approved for 3 months. Reauthorization will be approved for 12 months.

OTHER CRITERIA
All of the following must be met: 1. Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND 2. Clinical symptoms of LEMS, including dyspnea or functionally significant muscle weakness interfere with daily activities. AND 3. Patient has been evaluated for malignancy and treated for malignancy if present. Note: LEMS symptoms associated with malignancy may resolve after treatment directed at malignancy. AND 4. Documented trial and failure of at least one month, intolerance, or contraindication to pyridostigmine
GALAFOLD

MEDICATION(S)
GALAFOLD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
1. Given concurrently with enzyme replacement therapy [e.g. agalsidase beta (Fabrazyme®)]. 2. Severe renal impairment or end-stage renal disease.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a metabolic specialist, geneticist or prescriber with experience treating lysosomal storage disorders.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Diagnosis of Fabry Disease AND 2. Documentation that patient has an amenable galactosidase alpha gene (GLA) variant based on an in vitro assay.
GAMMA GLOBULIN - IGG

MEDICATION(S)
BIVIGAM, CARIMUNE NF NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S-D 10 G (IGA<1) SOL, GAMMAGARD S-D 5 G (IGA<1) SOLN, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PRIVIGEN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
The following off-label uses will be covered, according to criteria outlined below: hematopoietic stem cell transplant recipients, acute Guillain-Barre syndrome, dermatomyositis, relapsing-remitting type multiple sclerosis, exacerbation of myasthenia gravis, autoimmune hemolytic anemia.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation, a prior authorization form and documentation of medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

OTHER CRITERIA
Primary immune deficiency disorders (e.g., agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency, hyperIgM, or Wiskott-Aldrich syndrome) are covered by Medicare Part B only. For Kawasaki syndrome: documentation that use is for acute treatment given in conjunction with aspirin and within ten days of the onset of symptoms. For ITP: 1) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or dexamethasone) AND 2) Documentation of active bleeding, high-risk of bleeding, or a platelet count less than 30 cells per microliter. Reauthorization: 1) Documentation of platelet count less than 30 cells per microliter AND 2) Active bleeding or high risk of
bleeding. For prevention of infections in patients with chronic B cell lymphocytic leukemia: 1) Documented IgG less than 500 mg/dL OR 2) History of recurrent, severe infections. For dermatomyositis: 1) Documented trial, failure, intolerance or contraindication to: a) systemic corticosteroids (i.e. prednisone or methylprednisolone) AND b) immunosuppressant therapy (e.g., methotrexate, azathioprine) AND 2) Documentation of severe symptoms despite previous therapy with above agents. Reauthorization: 1) Documented response to therapy AND 2) Reduction in chronic corticosteroid use. For multifocal motor neuropathy: 1) Motor involvement of at least two nerves for more than one month, without symptoms of sensory abnormalities AND 2) Documentation of severe disease/disability. Reauthorization: Documented response to therapy. For relapsing-remitting type multiple sclerosis: Documentation of trial, failure, intolerance or contraindication to at least two standard therapies (e.g., glatiramer, interferon beta, dimethyl fumarate). For hematopoietic stem cell transplant recipients: Documentation of IgG less than 400 mg/dL within 100 days post-transplant. For acute Guillain-Barre Syndrome: 1) Documentation of symptom onset within 2 weeks or symptoms are severe (e.g. unable to ambulate independently) For chronic inflammatory demyelinating polyneuropathy: 1) Documented severe disability and 2) One of the following: a) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or methylprednisolone), b) Documentation of pure motor CIDP. For autoimmune hemolytic anemia: 1) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or methylprednisolone) AND 2) Documented trial, failure, intolerance or contraindication to another conventional therapy for autoimmune hemolytic anemia (e.g., cyclophosphamide, azathioprine, cyclosporine)
**MEDICATION(S)**
GATTEX

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, a gastroenterologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for six months.

**OTHER CRITERIA**
For short bowel syndrome (SBS) all of the following criteria must be met: 1. An initial nutritional assessment has been completed by a registered dietitian who has determined that oral/enteral nutrition is not sufficient to meet nutritional goals, 2. Patient is stable and dependent on parenteral support (fluids, electrolytes and/or nutrients) delivered at least three times per week, AND 3. The medication has been made part of a treatment plan established by a gastroenterologist or a hospital Metabolic Support Team that includes: a. Member evaluation indicates the possibility of success with treatment b. Defined parameters to measure response to therapy
MEDICATION(S)
ORILISSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient has osteoporosis or severe hepatic impairment.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial auth for 6 months. Reauth (150 mg daily dose only) will be approved for 1 yr up to 24 month

OTHER CRITERIA
For endometriosis: 1. Documentation that other causes of gynecologic pain have been ruled out (e.g., irritable bowel syndrome, interstitial cystitis, urinary tract disorders) 2. Documentation that GnRH therapy will be used with “add-back” hormonal therapy (e.g., norethindrone) to help prevent bone mineral density loss. Reauthorization: 1. Documentation of response to therapy (e.g., reduction in pain) AND 2. Documentation of continued use of “add-back” hormonal therapy (e.g., norethindrone) to help prevent bone mineral density loss.
HEMATOLOGY

MEDICATION(S)
ARANESP, EPOGEN, PROCRIT, RETACRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with uncontrolled hypertension.

REQUIRED MEDICAL INFORMATION
Hemoglobin and hematocrit levels within 30 days prior to initiation of therapy. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
1. All diagnoses with the exception of 2f, preoperative use in anemic patients scheduled for elective noncardiac, nonvascular surgery, must have documented Hemoglobin (HGB) levels of less than or equal to 10g/dl or hematocrit (HCT) levels of less than or equal to 30% within 30 days prior to initiation of therapy, AND 2. Must meet listed criteria below for each specific diagnosis: a. Treatment of Anemia in Chronic Renal Failure: epoetin or darbepoetin may be covered. b. Treatment of anemia due to chemotherapy in cancer and related neoplastic conditions (see exclusion criteria for non-covered indications): epoetin or darbepoetin may be covered when secondary to myelosuppressive anticancer chemotherapy. Note: May only be used up to 8 weeks following the final dose of myelosuppressive chemotherapy (subject to audit). c. Treatment of Anemia in Myelodysplastic Syndrome (MDS): epoetin or darbepoetin may be approved with documented endogenous erythropoietin levels of less than 500 mIU/ml. d. Anemia associated with zidovudine-treated HIV-infection patients: i. Coverage is for epoetin only with documented endogenous
serum erythropoietin level less than or equal to 500 mIU/ml and zidovudine dose less than or equal to 4200 mg/week. e. Anemia associated with the treatment of specific chronic diseases with agents known to cause anemia, epoetin may be covered with documentation that treatment will not be covered beyond 8 weeks after completion of therapy with agent known to cause anemia. f. Preoperative use in anemic patients scheduled for elective hip or knee surgery, epoetin may be covered when all of the following criteria are met: i. Member must be scheduled to undergo elective hip or knee surgery, ii. Member has preoperative anemia with pretreatment HGB between 10 and 13 g/dL., iii. Member is expected to lose more than 2 units of blood, iv. Member has received an appropriate preoperative workup revealing that the anemia appears to be that of chronic disease. Reauthorization requires documentation of continued medical necessity to maintain HGB 10-12g/dL or HCT 30-36%. Dosing should be adjusted for patients to achieve and maintain target HGB not to exceed 12g/dL. HGB and HCT levels must be drawn and documented within 30 days of the requested date of service.
HEPATITIS C

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR, SOFOSBUVIR-VELPATASVIR, VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting specific HCV genotype, recent liver fibrosis score, Child-Pugh score if patient has cirrhosis, baseline HCV RNA count, complete blood count, liver panel, and renal function status are required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease specialist, or providers experienced in Hepatitis C management.

COVERAGE DURATION
8 to 24 weeks based on medication, indication and established treatment guidelines

OTHER CRITERIA
Criteria will be applied consistent with current American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA) guidance.
HETLIOZ

MEDICATION(S)
HETLIOZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Sleep disorders other than Non-24

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a sleep specialist or neurologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
All of the following criteria must be met: 1. Member is totally blind (i.e. no light perception), 2. Documented diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as characterized by all of the following: a. Distinct pattern of sleeping and waking that drifts by a consistent time period every night AND b. History of periods of insomnia, excessive sleepiness, or both, which alternate with short asymptomatic periods, 3. Documented sleep study to exclude other sleep disorders, 4. Documentation of clinically significant distress or impairment in social, occupational, and other important areas of functioning. Reauthorization: 1. Documentation of improvement in social, occupational, and other important areas of functioning AND 2. Documentation of entrainment to the 24-hour circadian period.
HUMAN GROWTH HORMONES

MEDICATION(S)
OMNITROPE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary. May require the following specific tests depending on indication: Insulin tolerance test (ITT), GHRH/arginine stimulation test (GHRH/Arg stim), glucagon stimulation test (Glu stim), arginine-only stimulation test (Arg stim), Insulin-like growth factor (IGF-1) levels, pituitary hormone levels (LH, FSH, TSH, ACTH), body mass index (BMI), and/or genetic testing.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist.

COVERAGE DURATION
GHD: Initial/reauth for 12 months. SBS: 4 weeks. AIDS wasting: 12 months.

OTHER CRITERIA
For GHD in adults due to destructive lesions of the pituitary: 1. GHD due to head injury, radiation therapy, surgery, or trauma, and one of following biochemical confirmation tests: a. IGF-1 below 2.5 percentile (standard deviation score, Z-score below -2) for age/sex, b. ITT with peak GH less than/equal to 5.0 mcg/L, c. GHRH/Arg stim with low peak GH based on BMI (BMI less than 25: Peak GH less than/equal to 11.0 mcg/L, BMI 25-30: Peak GH less than/equal to 8.0 mcg/L, BMI greater than/equal to 30: Peak GH less than/equal to 4.0 mcg/L), d. Glu stim with peak GH less than/equal to 3.0 mcg/L, e. Arg stim with peak GH less than/equal to 0.4 mcg/L, 2. GHD due to organic disease (e.g. hypothalamic or pituitary disease): a. At least 2 other pituitary hormone deficiencies (i.e. TSH, ACTH, Gonadotropins, and ADH) AND one of the
biochemical confirmation tests above (1. a-e) OR b. Three pituitary hormone deficiencies (other than GH) requiring hormone replacement AND an IGF-1 level below 84 ng/ml. Initial dose will be approved at no more than 0.04 mg/kg body weight/week, or no more than 0.2 mg/day for obese and/or diabetic patients. Reauthorization dose will be approved at no more than 0.08 mg/kg body weight/week. Reauthorization requires evidence of improved quality of life, good tolerability and annual documentation of IGF-I levels with appropriate dosage adjustments. For GHD in adults who had GHD as a child: Retesting should occur unless known mutation/genetic cause, embryopathic lesions, or irreversible structural damage. 1. After linear growth has stopped (GV less than 2.5cm/yr), GH is stopped for at least 1 month, patients retested, and have the following results: a. At least 2 other pituitary hormone deficiencies (i.e. TSH, ACTH, Gonadotropins, and ADH) AND b. Two of the following: i. IGF-I less than 50th percentile for age/sex (If IGF-I less than 2.5 percentile, no further testing is required), ii. ITT with peak GH less than/equal to 5.0 mcg/L, iii. GHRH/Arg stim with low peak GH based on BMI (BMI less than 25: Peak GH less than/equal to 11.0 mcg/L, BMI 25-30: Peak GH less than/equal to 8.0 mcg/L, BMI greater than/equal to 30: Peak GH less than/equal to 4.0 mcg/L), iv. Glu stim with peak GH less than/equal to 3.0 mcg/L, v. Arg stim with peak GH less than/equal to 0.4 mcg/L. Initial dose will be approved at no more than 0.04 mg/kg body weight/week, or no more than 0.2 mg/day for obese and/or diabetic patients. Reauthorization dose will be approved at no more than 0.08 mg/kg body weight/week. Reauth requires evidence of improved QOL, good tolerability and annual IGF-I levels with appropriate dosage adjustments. For AIDS wasting: 1. Involuntary loss of at least 10% body weight, 2. Absence of other related illnesses contributing to weight loss, AND 3. Documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents. For short bowel syndrome (SBS): ability to ingest solid food.
INCRELEX

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Subjects with secondary forms of IGF-1 deficiency (e.g., GH deficiency, malnutrition, hypothyroidism, chronic treatment with pharmacologic doses of anti-inflammatory steroids)

REQUIRED MEDICAL INFORMATION
Height standard deviation score, growth velocity, IGF-1 levels, GH levels, GH antibody levels, bone radiographs. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For severe primary IGF-1 deficiency all of the following criteria must be met: 1. Height standard deviation score of less than or equal to -3.0, 2. Basal insulin-like growth factor (IGF)-1 standard deviation score of less than or equal to -3.0, 3. Normal or elevated growth hormone (GH) levels, AND 4. Documentation of open epiphyses by bone radiograph. For Growth hormone (GH) gene deletion: 1. Documentation of open epiphyses by bone radiograph AND 2. Patient has developed neutralizing antibodies to growth hormone. Reauthorization requires all of the following criteria to be met: 1. Evidence that the medication remains effective, 2. Growth velocity is above 2.0 cm/year, 3. Evidence of open epiphyses, and 4. Documentation of expected adult height goal that is not yet obtained.
MEDICATION(S)
JUXTAPI-D, KYNAMRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LDL level or genetic confirmation of Homozygous Familial Hypercholesterolemia. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board certified lipidologist

COVERAGE DURATION
Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) as evidenced by: a. Genetic confirmation OR b. Untreated LDL-C greater than 500 mg/dl and xanthoma OR c. Both parents are heterozygous FH. 2. One of the following: a. Current use of high-intensity statin therapy for at least 3 months, defined as atorvastatin 80 mg daily or rosuvastatin 40 mg daily, OR b. Documented statin intolerance. AND 3. An adequate trial and failure (3 months of therapy), contraindication or intolerance to the use of a formulary PCSK-9 inhibitor. Initial reauthorization must show documentation that LDL-C has decreased from pre-treatment levels.
MEDICATION(S)
CLONIDINE HCL ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 6 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
1. Documented trial, failure, intolerance or contraindication to guanfacine extended-release (Intuniv®) AND
2. One of the following criteria must be met: a. Member is 65 years or older OR b. Documented trial and failure, intolerance, or contraindication to a formulary stimulant medication indicated for the treatment of attention deficit hyperactivity disorder (ADHD).
MEDICATION(S)
KORLYM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Current pregnancy

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. Documentation that the patient has hyperglycemia secondary to endogenous Cushing’s Syndrome (defined as hypercortisolism that is not a result of chronic administration of high dose glucocorticoids), AND
2. Documentation that the patient has type 2 diabetes mellitus or glucose intolerance, AND
3. Documentation that the patient has failed surgery or is not a candidate for surgery
MEDICATION(S)
KUVAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Doses greater than 20mg/kg/day will not be approved.

REQUIRED MEDICAL INFORMATION
Average blood phenylalanine (Phe) levels. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For phenylketonuria (PKU): Documentation that the patient’s pre-treatment phenylalanine (Phe) blood level is above 6 mg/dL (360 micromol/L) in children less than 12 years of age, or above 15 mg/dL (900 micromol/L) for ages 12 and older. Reauthorization: Documentation that average blood Phe levels have decreased by at least 30% for initial reauthorization and remain 30% below pretreatment baseline for continued authorization thereafter.
MEDICATION(S)
LIDOCAINE 5% PATCH

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Diabetic peripheral neuropathy and cancer-related neuropathic pain.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance, or contraindication to gabapentin. Reauthorization will require documentation of response to therapy.
LONG-ACTING OPIOIDS

MEDICATION(S)
BUPRENORPHINE, FENTANYL 100 MCG/HR PATCH, FENTANYL 12 MCG/HR PATCH, FENTANYL 25 MCG/HR PATCH, FENTANYL 50 MCG/HR PATCH, FENTANYL 75 MCG/HR PATCH, HYDROCODONE BITARTRATE ER, LEVORPHANOL 2 MG TABLET, METHADONE 10 MG/5 ML SOLUTION, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 10 MG/ML VIAL, METHADONE HCL 200 MG/20 ML VL, METHADONE HCL 5 MG TABLET, XTAMPZA ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Use as an as-needed (prn) analgesic.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
patient. For patients initiating long-acting opioid therapy for non-malignant pain, all of the following criteria must be met: 1. Documentation of chronic non-malignant pain (lasting longer than 3 months) that is severe enough to require around-the-clock analgesic therapy, AND 2. Documentation of trial and failure of scheduled short-acting opioid therapy, AND 3. Documentation of trial and failure, contraindication, or intolerance to long-acting morphine sulfate therapy, AND 4. Documentation of a signed pain management agreement between the prescriber and patient.
MEDICATION(S)
MAVENCLAD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
May be approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist

COVERAGE DURATION
Initial authorization/reauthorization will be approved for 1 year, up to total treatment of 2 years.

OTHER CRITERIA
Documented trial and failure, intolerance, or contraindication to two (2) conventional therapies for multiple sclerosis.
MEDICATION(S)
MIGLUSTAT, RAVICTI, SODIUM PHENYL BUTYRATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Initial authorization: 1. Confirmation of FDA-labeled indication AND 2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis (e.g., high-quality peer reviewed literature, guidelines, other clinical information). Reauthorization: 1. Documentation of successful response to therapy AND 2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis (e.g., high-quality peer reviewed literature, guidelines, other clinical information).
MEDICATION(S)
MIACALCIN 400 UNIT/2 ML VIAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For the treatment or prevention of osteoporosis: BMD T-score, FRAX.

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial approval and renewal for 1 year.

OTHER CRITERIA
For the treatment or prevention of osteoporosis:
Patient has indication for treatment as evidenced by one (1) of the following:
1. Patient has a history of multiple or severe vertebral fractures, or history of fragility fractures
2. Patient has a spine or hip bone mineral density (BMD) T-score less than or equal to -2.5 and high risk for fracture, defined as one (1) of the following:
   a. Age more than 80 years
   b. Chronic glucocorticoid use
   c. Documented increased fall risk
3. Patient has a spine or hip BMD T-score less than or equal to -2.5 and one (1) of the following:
a. Documented failure to anti-resorptive therapy (e.g., denosumab, bisphosphonates). Failure is defined as a new fracture or worsening BMD while adherent to therapy.
b. Documented contraindication or intolerance to therapy with all of the following:
   i. Denosumab,
   ii. Oral bisphosphonate (e.g., alendronate), or
   iii. IV bisphosphonate therapy (i.e., zoledronic acid).
4. Patient has a spine or hip BMD T-score between -2.5 and -1.0 and BOTH of the following:
a. Fracture Risk Assessment (FRAX) probability score for hip fracture of at least 3% or, for other major osteoporosis fracture, of at least 20%.
b. One (1) of the following:
   i. Documented failure to anti-resorptive therapy (e.g., denosumab, bisphosphonates). Failure is defined as a new fracture or worsening BMD while adherent to therapy.
   ii. Documented contraindication or intolerance to therapy with all of the following:
      1. Denosumab
      2. Oral bisphosphonate (e.g., alendronate)
      3. IV bisphosphonate therapy (i.e., zoledronic acid).

For Treatment of Paget’s Disease:
1. Documentation of trial and failure of bisphosphonate therapy. Failure is defined as no improvement in pain and/or function.
2. Documented contraindication or intolerance to therapy with both of the following:
a. Oral bisphosphonate (e.g., alendronate)
b. IV bisphosphonate therapy (i.e., zoledronic acid)
MEDICATION(S)
MULPLETA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a hematologist, gastroenterologists or liver specialist.

COVERAGE DURATION
Initial and reauthorization will be approved for 1 month (1 course of treatment).

OTHER CRITERIA
All of the following criteria must be met: 1. Diagnosis of chronic liver disease, AND 2. Platelet count of less than 50,000 platelets/microliter, AND 3. Documentation that patient will have a scheduled medical or dental procedure within the next 30 days and therapy will be started 8-14 days prior to the procedure.
MEDICATION(S)
MYALEPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Metabolic parameters (i.e., HbA1c, triglyceride levels, fasting insulin levels). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
1. Diagnosis of congenital or acquired generalized lipodystrophy (i.e., not related to HIV, nor obesity not related to leptin deficiency) AND 2. Documentation of at least one of the following metabolic complications of leptin deficiency: a. Diabetes mellitus b. Triglyceride levels greater than or equal to 200 mg/dL c. Increased fasting insulin levels greater than or equal to 30 microU/mL AND 3. Documentation that the patient has not had a response to current standards of care for lipid and diabetic management.
Reauthorization requires documentation of response to therapy as indicated by one of the following: a. Sustained reduction in hemoglobin A1c level from baseline or b. Sustained reduction in triglyceride levels from baseline
MEDICATION(S)
NAYZILAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan

OTHER CRITERIA
N/A
NEXLETOL/NEXLIZET (PENDING CMS APPROVAL)

MEDICATION(S)
NEXLETOL, NEXLIZET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For all indications, all of the following must be met: 1. Trial and failure of high-intensity statin therapy for at least 3 months, defined as atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily, or the patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a statin AND 2. Trial and failure of a formulary PCSK-9 inhibitor (i.e., Repatha®) or the patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a PCSK-9 inhibitor AND 3. Fasting LDL-C greater than or equal to 70 mg/dl despite therapies outlined above AND 4. Must meet listed criteria below for each specific diagnosis:
a. For familial hypercholesterolemia, confirmed diagnosis by one of the following: i. Genetic mutation in one of the following genes: LDLR, APOB, ARH adaptor protein 1/LDLRAP1, or PCSK9, ii. A Dutch Lipid Clinic Network Criteria score of greater than or equal to 6, or iii. LDL-C greater than 190 mg/dl (pretreatment or highest level while on treatment) and secondary causes have been ruled out. Secondary causes may include hypothyroidism, nephrosis, or extreme dietary patterns. b. For atherosclerotic cardiovascular disease (ASCVD), history of one of the following: i. Acute coronary syndromes, ii. History of myocardial infarction, iii. Stable/unstable angina, iv. Coronary or other arterial revascularization, v. Stroke or transient ischemic attack, vi. Peripheral artery disease presumed to be of atherosclerotic origin, vii. Clinically significant multi-vessel coronary heart disease presumed to be of atherosclerotic origin. Initial reauthorization requires documentation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a cardiologist or endocrinologist.

COVERAGE DURATION
Initial auth approved for 6 months. Reauth will be approved until no longer eligible with the plan.

OTHER CRITERIA
N/A
NOCTIVA

MEDICATION(S)
NOCTIVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Serum sodium levels. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 50 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months, reauthorization will be approved for 1 year

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection, 2. Patient has a 6 month history of awaking at least two times per night to void, 3. All other causes of nocturia have been ruled out or adequately treated [e.g., benign prostatic hyperplasia (BPH), overactive bladder (OAB), obstructive sleep apnea (OSA), medications], 4. Documentation of trial and failure of desmopressin tablets, AND 5. Documentation of a normal serum sodium level based on laboratory reference range within the previous 60 days. Reauthorization requires: 1. Documentation of a normal serum sodium level AND 2. Documentation that the member has had a decrease in nighttime wakening from baseline.
MEDICATION(S)
NORTHERA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be for two months. Reauthorization will be for six months.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Documentation of a diagnosis of symptomatic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, 2. Documentation of a screen for treatable causes of orthostatic hypotension and currently being treated for the identified treatable cause of orthostatic hypotension, AND 3. Documented trial, failure, intolerance or contraindication to midodrine. Reauthorization: 1. Documented response to initial therapy (improvement in severity from baseline symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out) AND 2. Documentation that periodic evaluations are being done to assess continued efficacy and medical rationale for continuing therapy, as none of the clinical trials demonstrated continued efficacy beyond 2 weeks of treatment.
MEDICATION(S)
NOURIANZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with a major psychotic disorder

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist

COVERAGE DURATION
Initial authorization will be approved for 6 months, reauthorization will be approved for 1 year

OTHER CRITERIA
Initial authorization: 1. Confirmed diagnosis of Parkinson’s Disease 2. Documentation the patient is experiencing OFF episodes with current use of oral carbidopa/levodopa therapy 3. Documentation of attempts to adjust dosing and formulation of carbidopa/levodopa to manage OFF symptoms 4. Documentation that at least one other agent has been used as adjunctive therapy with carbidopa/levodopa to reduce number and frequency of OFF episodes (e.g. dopamine agonist, COMT inhibitor, or MAO-B inhibitor). Reauthorization: Documentation that patient had a positive response to therapy, such as decrease in number, duration or severity of OFF episodes
NUCALA

MEDICATION(S)
NUCALA 100 MG/ML AUTO-INJECTOR, NUCALA 100 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
For asthma: approved for patients 6 years of age and older. For EGPA: approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
For eosinophilic asthma: must be prescribed by or in consultation with an asthma specialist (such as a Pulmonologist, Immunologist, or Allergist) For Eosinophilic Granulomatosis with Polyangiitis: must be prescribed by or in consultation with a Pulmonologist, Neurologist, or Rheumatologist

COVERAGE DURATION
Initial authorization will be approved for 6 months, reauthorization will be approved for 1 year

OTHER CRITERIA
For eosinophilic asthma: 1. Documentation of one of the following: a. A blood eosinophil count of at least 150 cells/microliter in the past 3 months b. A blood eosinophil count of at least 300 cells/microliter in the past 12 months c. Past history of eosinophilic asthma if currently on daily maintenance treatment with oral glucocorticoids 2. Documentation of a trial/failure of a combination of a high-dose inhaled corticosteroid and a long-acting inhaled beta2-agonist unless there is intolerance or contraindication to the medications 3. Documentation of severe asthma with inadequate control, such as frequent exacerbations requiring oral corticosteroids, hospitalizations, or poor asthma control scores (e.g., ACT score less than 20 or an ACQ greater than 1.5) Reauthorization: Documentation of response to therapy such as an improvement in
baseline asthma control scores, reduction in exacerbations/hospitalizations or oral corticosteroids. For Eosinophilic Granulomatosis with Polyangiitis (EGPA): 1. At least two of the following clinical findings: biopsy evidence of eosinophilic vasculitis, motor deficit or nerve conduction abnormality, pulmonary infiltrates, sinonasal abnormality, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura or positive test for ANCA and 2. Documentation of inadequate control of EGPA while on oral corticosteroids and immunosuppressive therapy (such as cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil) or a contradiction/intolerance to these therapies Reauthorization: Documentation of a positive response to therapy, such as no active vasculitis, a reduction in relapses or reduction of daily oral corticosteroids
NUDEXTA

MEDICATION(S)
NUDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Initial authorization: Documentation of a neurologic disease or brain injury (such as traumatic brain injury, stroke, dementia, multiple sclerosis, amyotrophic lateral sclerosis [ALS], or Parkinson’s disease).
Reauthorization: Documentation of response to therapy, defined as a reduction in episodes of laughing, crying, and/or emotional lability.
NUPLAZID

MEDICATION(S)
NUPLAZID 10 MG TABLET, NUPLAZID 34 MG CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mini-mental status exam (MMSE) score or Saint Louis University Mental Status (SLUMS) exam score. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist, psychiatrist, or geriatrician.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Initial authorization requires 1. Diagnosis of Parkinson’s disease with hallucinations and/or delusions causing clinically significant distress, with delirium ruled out AND 2. Mini-mental status exam (MMSE) score greater than or equal to 21 or Saint Louis University Mental Status (SLUMS) exam score greater than or equal to 16, to indicate that patients can self-report symptoms AND 3. Documented trial, failure, intolerance to clozapine or quetiapine OR contraindication to both clozapine and quetiapine. Reauthorization requires documentation of reduction in frequency and/or severity of hallucinations and/or delusions.
MEDICATION(S)
OCALIVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Laboratory monitoring: total bilirubin (tBili), alkaline phosphatase (ALP), and aspartate aminotransferase (AST) and Child-Pugh class. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a gastroenterologist or hepatologist.

COVERAGE DURATION
Initial authorization will be approved for 4 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. Confirmed diagnosis of Primary Biliary Cirrhosis with two of three of the following criteria are met: a. Elevated alkaline phosphatase (greater than upper limit of normal [ULN]), b. Presence of antimitochondrial antibody (AMA) (titer greater than or equal to 1:40), c. Liver biopsy consistent with primary biliary cirrhosis AND 2. Both of the following: a. Use of ursodiol for a minimum of 6 months and failure to achieve: ALP less than or equal to 1.5 X ULN, AST less than or equal to 1.5 X ULN, and total bilirubin (tBili) less than or equal to ULN. If laboratory reference values for ALP are not available, the values used in a clinical trial may be used for this assessment (ULN = 117 U/L for women, 129 U/L for men). AND b. Documentation that ursodiol will be continued unless there were intolerable adverse effects with ursodiol AND 3. Dose is appropriate based on an assessment of hepatic function (Child-Pugh class). If Child-Pugh B or C, start at 5 mg once weekly (can be increased if needed to a maximum of 10mg twice weekly). Reauthorization: 1.
Maintenance of biochemical response (ie. alkaline phosphatase (ALP) less than or equal to 1.67 times ULN, total bilirubin (tBili) less than or equal to ULN, and an ALP decrease of at least 15%) 2. Documentation that ursodiol will be continued, if tolerated 3. Hepatic function is assessed at least annually. If Child-Pugh B or C, dose should not exceed 10mg twice weekly)
OCTREOTIDE

MEDICATION(S)
OCTREOTIDE ACETATE, SANDOSTATIN LAR, SANDOSTATIN LAR DEPOT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Variceal bleeding: 1 month. Other indications: Initial and reauthorization for 12 months

OTHER CRITERIA
For treatment of diarrhea, the patient must have documentation of one of the following: 1. Severe diarrhea or flushing caused by a carcinoid tumor, OR 2. Severe diarrhea caused by a vasoactive intestinal peptide tumors, OR 3. Severe diarrhea caused by chemotheraphy or AIDS and has failed treatment with loperamide. Reauthorization will require documentation of response to therapy, defined as a reduction in diarrhea episodes. For acromegaly: 1. Confirmed diagnosis of acromegaly, AND 2. Documentation of an inadequate response to surgery or pituitary irradiation or patient is not a candidate for surgical resection and pituitary irradiation, AND 3. History of failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Reauthorization will require documentation of a positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). For variceal bleeding: Documentation that therapy will be used short term (less than 1 month), as use beyond one month is not considered medically necessary.
ORENCIA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a dermatologist or rheumatologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency) and 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent, 3. Documentation of trial and failure, intolerance, or contraindication to at least two (2) preferred biologic agents: Use of TWO preferred biologics (Enbrel, Humira, Rinvoq) is required for
diagnosis of rheumatoid arthritis. Use of TWO preferred biologics (Enbrel, Humira) is required for diagnosis of juvenile idiopathic arthritis. Use of TWO preferred biologics (Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis.
OSMOLEX ER

MEDICATION(S)
OSMOLEX ER 129 MG TABLET, OSMOLEX ER 193 MG TABLET, OSMOLEX ER 258 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist, psychiatrist or expert in the treatment of movement disorders

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. Documentation of Parkinson’s Disease or drug-induced extrapyramidal symptoms, AND 2. Documented trial and failure or intolerance to immediate release amantadine
OSTEOANABOLIC AGENTS

MEDICATION(S)
FORTEO, TYMLOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For the treatment or prevention of osteoporosis: BMD T-score or FRAX. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist or rheumatologist

COVERAGE DURATION
Initial approval and renewal for 1 year. Total duration in lifetime limited to 2 years.

OTHER CRITERIA
For the treatment or prevention of osteoporosis: 1. Documentation of trial and failure of bisphosphonate therapy or contraindication/intolerance to both oral and IV bisphosphonate therapy, AND 2. One of the following criteria: A. Documented clinical diagnosis of osteoporosis [defined as a non-traumatic, non-pathologic spinal fracture OR spine, femoral neck or hip bone mineral density (BMD) T-score less than or equal to -2.5]. OR B. Documented risk of osteoporosis (defined as BMD T-score between -1.0 and –2.5) AND meeting one of two risk assessments a) one of the following risk factors: i. previous fracture, ii. history of hip or spine fracture in first degree relative, iii. low body weight (less than 127 lbs. for women), iv. smoking, excess alcohol intake, v. secondary osteoporosis (e.g. rheumatoid arthritis), vi. history of falls, b) FRAX Hip fracture probability greater than or equal to 3% or other major osteoporosis fracture probability greater than or equal to 20% OR C. One of the following chronic glucocorticosteroid use: a) greater than 20 mg/day for longer than 1 month b) 5-20 mg/day for longer than 3 months in post menopausal women not on
estrogen c) 5-20 mg/day for longer than 3 months AND T-score less than -1.5
OTEZLA

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan

OTHER CRITERIA
For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency), AND 2. One of the following: a. Patient is not currently being treated with a biologic immunomodulator, OR b. Patient is currently being treated with a biologic immunomodulator AND will discontinue the biologic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, AND 2. Documentation of trial and failure, intolerance, or contraindication to one conventional therapy prerequisite for the requested indication (see notes below), AND 3. One of the following: a. Patient is not currently being treated with a biologic immunomodulator, OR b. Patient is currently being treated with a biologic immunomodulator AND will discontinue the biologic immunomodulator prior to starting the requested agent. Notes: Use of ONE conventional agent prerequisite is required for diagnoses of psoriatic arthritis and plaque psoriasis.
Formulary conventional agents for psoriatic arthritis include methotrexate, hydroxychloroquine, sulfasalazine, minocycline, or leflunomide. Formulary conventional topical or systemic agents for plaque psoriasis include topical corticosteroids, tazarotene, cyclosporine, calcipotriene, methotrexate, tacrolimus, pimecrolimus, or acitretin.
MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an ophthalmologist

COVERAGE DURATION
Initial and reauthorization will be approved for 8 weeks

OTHER CRITERIA
All of the following must be met: 1. Patient has a diagnosis of neurotrophic keratitis in the affected eye(s) with diagnosis supported by chart notes, AND 2. The request specifies the affected eye(s) intended for treatment
MEDICATION(S)
PALYNZIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Baseline blood phenylalanine (Phe) levels for initiation of therapy. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a metabolic disease specialist or a provider who specializes in the treatment of PKU.

COVERAGE DURATION
Initial authorization for 6 months, reauthorization for 1 year

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Diagnosis of phenylketonuria (PKU) and 2. Blood phenylalanine concentration greater than 600 micromol/L despite management with sapropterin (Kuvan). For reauthorization ONE of the following criteria must be met: 1. Documentation that in blood phenylalanine concentration levels have decreased by at least 20% from baseline and remain at least 20% below pretreatment baseline OR 2. Documentation of a blood phenylalanine concentration less than or equal to 600 micromol/L.
**PARATHYROID HORMONE**

**MEDICATION(S)**
NATPARA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Corrected serum-albumin calcium levels, serum levels of 25-OH vitamin D. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, an endocrinologist.

**COVERAGE DURATION**
Initial authorization for 6 months and reauthorization will be approved for 1 year.

**OTHER CRITERIA**
All of the following criteria must be met: 1. Patient must be diagnosed with permanent/chronic hypoparathyroidism (i.e. not acute post-surgical hypoparathyroidism), 2. Confirmed serum albumin corrected calcium is above 7.5 mg/dL (1.9 mmol/L), AND 3. Confirm serum 25-hydroxyvitamin D is greater than or equal to 30 ng/mL (75 nmol/L).
MEDICATION(S)
ABELCET, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR SODIUM, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMBISOME, AMINOSYN II 15% IV SOLUTION, AMPHOTERICIN B 50 MG VIAL, ASTagraF XL, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BONIVA 3 MG/3 ML SYRINGE, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CALCITONIN-SALMON, CALCITRIOL 0.25 MCG CAPSULE, CALCITRIOL 0.5 MCG CAPSULE, CALCITRIOL 1 MCG/ML AMPUL, CALCITRIOL 1 MCG/ML SOLUTION, CELLCEPT 200 MG/ML ORAL SUSP, CINACalcET HCL, CROMOLYN 20 MG/2 ML NEB SOLN, CUTAQUIG, CUvITRU, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 250 MG/5 ML AMPUL, CYCLOSPORINE MODIFIED, DERMACINRX EMPIRICAINE, DERMACINRX PRIZOPAK, DOXERCALCIFEROL, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, ENVARSUS XR, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, GAMASTAN, GAMASTAN S-D, GANCICLOVIR 500 MG VIAL, GENGRAF, HEPARIN 10,000 UNIT/10 ML VIAL, HEPARIN 2,000 UNIT/2 ML VIAL, HEPARIN 30,000 UNIT/30 ML VIAL, HEPARIN SOD 1,000 UNIT/ML VIAL, HIZENTRA, HYqVIA, IBANDRONATE 3 MG/3 ML SYRINGE, IBANDRONATE 3 MG/3 ML VIAL, INTRALIPID, IPPrATROPIUM BR 0.02% SOLN, IPPrATROPIUM-ALBUTEROL, LEVOCARNITINE 1 G/10 ML SOLN, LEVOCARNITINE 330 MG TABLET, LIDO-PRILo CAINE PACK, LIDOCAINE 5% OINTMENT, LIDOCAINE-PRILoCAINE, LIDOprIL, LIDOprIL XR, LIPOZONEPAK, MEDOLOR PAK, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, NEBUpENT, NULOJIX, NUTRILIPID, PAMIDRONATE DISODIUM, PARICALCITOL, PLENAminE, PRILoLID, PROGRAF 5 MG/ML AMPULE, PULMOZYME, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB, RELADOR PAK, RELADOR PAK PLUS, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TABLET, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBRAMYCIN 300 MG/5 ML AMPULE, ZEMPLAR 10 MCG/2 ML VIAL, ZEMPLAR 2 MCG/ML VIAL, ZEMPLAR 5 MCG/ML VIAL, ZOLEDRONIC ACID, ZORTRESS

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.
PCSK-9 INHIBITORS

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Low-density lipoprotein cholesterol (LDL-C) levels. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For ASCVD: must be prescribed by or in consultation with a cardiologist. For FH: must be prescribed by or in consultation with a cardiologist, endocrinologist, or board certified lipidologist.

COVERAGE DURATION
Initial authorization for one year. Reauth will be approved until no longer eligible with plan.

OTHER CRITERIA
1. For all indications must have documentation of one of the following: a. Trial and failure of high-intensity statin therapy for at least 3 months, defined as atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily, OR b. The patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a statin AND 2. Must meet listed criteria below for each specific diagnosis: a. For primary hyperlipidemia, including Heterozygous Familial Hypercholesterolemia (HeFH) OR Homozygous Familial Hypercholesterolemia (HoFH), confirmed diagnosis by one of the following: i. Genetic mutation in one of the following genes: LDLR, APOB, ARH adaptor protein 1/LDLRAP1, or PCSK9, ii. A Dutch Lipid Clinic Network Criteria score of greater than or equal to 6, or iii. LDLC greater than 190 mg/dl (pretreatment or highest level while on treatment) and secondary causes have been ruled out. Secondary causes may include hypothyroidism, nephrosis, or extreme dietary patterns. b. For atherosclerotic cardiovascular
disease (ASCVD): i. LDL-C greater than 70 mg/dl and history of clinical ASCVD, defined as one of the following: i. Acute coronary syndromes, ii. History of myocardial infarction, iii. Stable/unstable angina, iv. Coronary or other arterial revascularization, v. Stroke or transient ischemic attack, vi. Peripheral artery disease presumed to be of atherosclerotic origin, vii. Clinically significant multi-vessel coronary heart disease presumed to be of atherosclerotic origin. Initial reauthorization: Documentation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels
PREVYMIS

MEDICATION(S)
PREVYMIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a hematologist, oncologist, transplant specialist, or infectious disease specialist.

COVERAGE DURATION
Initial authorization will be approved for 3 months, up to 100 days post-transplant.

OTHER CRITERIA
All of the following criteria must be met: 1. Patient is within 100 days post-allogeneic transplant, 2. Cytomegalovirus (CMV) recipient positive, 3. Patient has ONE of the following: a. Graft versus host disease (GVHD) requiring greater than or equal to 1 mg/kg/day use of prednisone [or equivalent], b. Receipt of lymphocyte depleting therapy (e.g., antithymocyte globulin [ATG], antithymocyte globulin equine [ATGAM], antithymocyte globulin rabbit [thymoglobulin], alemtuzumab, fludarabine) within the previous 6 months, c. Transplant was a cord blood allograft, OR d. History of CMV drug resistance within the past 6 months, AND 4. If IV letermovir is being requested, rationale for not using oral formulation must be provided (e.g. patient is unable to swallow).
MEDICATION(S)
PROCYSBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
All of the following criteria must be met: 1. Confirmed diagnosis of nephropathic cystinosis as evidenced by measuring leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene AND 2. Documentation of trial and failure, intolerance, or contraindication to immediate release cysteamine capsules (Cystagon).
PROGRAF

MEDICATION(S)
PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization until no longer eligible with the plan

OTHER CRITERIA
1. Documentation that medically necessary dose of tacrolimus cannot be achieved through use of generic tacrolimus capsules (which are available in 0.5, 1, and 5 mg strengths), OR 2. Documentation that the patient has difficulty swallowing generic tacrolimus capsules
MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Platelet count. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with an oncologist, hematologist, infectious disease specialist, gastroenterologist, or hepatologist.

COVERAGE DURATION
Initial authorization will be approved for 4 months. Reauthorization will be approved for 6 months.

OTHER CRITERIA
For chronic immune thrombocytopenia (ITP) all of the following criteria must be met: 1. Patient is at risk for bleeding with a platelet count of less than 30,000 per microliter AND 2. Documentation of trial and failure, intolerance, or contraindication to at least one of the following: a. Systemic corticosteroids, b. Immune gamma globulin, OR c. Splenectomy. For severe aplastic anemia: 1. Patient is at risk for bleeding with a platelet count of less than or equal to 30,000 per microliter. For reauthorization for ITP or severe aplastic anemia: Platelet levels demonstrating response to therapy as well as documentation that therapy continues to be required to maintain a platelet count of at least 50,000 per microliter.
PULMONARY ARTERIAL HYPERTENSION

MEDICATION(S)
ADEMPAS, ALYQ, AMBRISONTAN, BOSENTAN, LETAIRIS, OPSUMIT, ORENITRAM ER, SILDENAFIL 10 MG/12.5 ML VIAL, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TRACLEER 32 MG TABLET FOR SUSP, UPTRAVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a pulmonologist or cardiologist

COVERAGE DURATION
Initial auth will be approved for 1 year. Reauth approved until no longer eligible with the plan.

OTHER CRITERIA
All of the following criteria must be met: 1. Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (PAH) as defined by: a. Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg at rest or greater than 30 mmHg with exercise AND b. Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, 2. Patient has documented World Health Organization (WHO) Group 1 classification (PAH). Reauthorizations requires documentation of response to therapy.
MEDICATION(S)
RADICAVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Forced vital capacity (FVC), completed Amyotrophic Lateral Sclerosis (ALS) Functional Rating Scale-Revised (ALSFR-R) score form take at baseline and current functional ability in activities of daily living (ADLs). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist with expertise in ALS.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For initial authorization, all of the following criteria must be met: 1. Diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) per the El Escorial (Airlie House) Criteria, 2. Diagnosis of ALS within the last 2 years, 3. Baseline ALSFRS-R scores with greater than or equal to 2 points in each individual item, AND 4. FVC greater than or equal to 80% (taken within the past 3 months). Reauthorization requires: 1. Documentation of a clinical benefit from therapy such as stabilization of functional ability and maintenance of ADLs AND 2. Patient must not have more than a 6 point decline in the ALSFRS-R from baseline.
MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 90 days. One additional auth may be approved for 90 days.

OTHER CRITERIA
For initial authorization, documentation must be submitted showing adequate blood tissue supply to the affected area. For reauthorization, documentation must be submitted showing an adequate response defined by a 30% reduction or greater in ulcer size. There is no medical evidence to justify ongoing treatment after 180 days.
RELISTOR

MEDICATION(S)
RELISTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Known or suspected gastrointestinal obstruction.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 1 year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Patient is on chronic opioid therapy, AND 2. Documentation of less than three (3) spontaneous bowel movements per week, AND 3. Documentation of trial and failure (at least two weeks of therapy), intolerance, or contraindication to routine laxative therapy with lactulose, AND 4. Documentation of trial and failure (at least two weeks of therapy), intolerance, or contraindication to one of the following: a. naloxegol (Movantik), b. lubiprostone (Amitiza), or c. naldemedine (Symproic)
MEDICATION(S)
RITUXAN, RITUXAN HYCELA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an oncologist, rheumatologist, neurologist (in the case of multiple sclerosis), dermatologist (in the case of pemphigus vulgaris), or nephrologist (in the case of renal disease).

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
For oncologic diagnoses: Use must be for a FDA approved indication or indication supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher. For Rheumatoid Arthritis: 1. Documentation of trial, failure, intolerance, or contraindication to two of the following targeted immune modulators: Enbrel, Humira, Remicade AND 2. Documentation that rituximab will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another DMARD, unless medical rationale is provided to support monotherapy. For vasculitis (including granulomatosis with polyangiitis [GPA, formerly known as Wegener’s Granulomatosis], microscopic polyangiitis [MPA], and polyarteritis nodosa): 1. Documentation that rituximab will be given in combination with glucocorticoids. AND 2. One of the following: a. Documentation of severe disease (e.g., critical organ system involvement)
OR b. Documentation of trial and failure, intolerance, or contraindication to systemic immunosuppressant therapy with cyclophosphamide or methotrexate. For immune thrombocytopenia (ITP): 1. Documentation of trial, failure, intolerance, or contraindication to systemic corticosteroid therapy AND 2. Documentation of active bleeding, or high-risk of bleeding, or a platelet count less than 30 x 10^9/L. For relapsing and remitting multiple sclerosis (RRMS): 1. Documentation of trial, failure, intolerance, or contraindication to one (1) injectable preferred disease modifying agents which include: interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), peginterferon beta-1a (Plegridy), glatiramer (Copaxone, Glatopa) AND 2. Documentation of trial, failure, intolerance, or contraindication to at least two (2) oral preferred disease modifying agents which include: dimethyl fumarate (Tecfidera), fingolimod (Gilenya), teriflunomide (Aubagio). For refractory myasthenia gravis: 1. Documentation that patient has severely impaired function due to myasthenia gravis AND 2. Documented trial, failure, intolerance or contraindication to at least two (2) of the following conventional therapies: a. acetylcholinesterase inhibitors (e.g., pyridostigmine) b. corticosteroids (e.g., prednisone, methylprednisolone) c. immunosuppressive agents (e.g., azathioprine, cyclosporine, mycophenolate) d. plasma exchange. For autoimmune hemolytic anemia (AIHA): 1. In patients diagnosed with warm AIHA a. Documentation of trial, failure, intolerance, or contraindication to glucocorticoids AND b. Documentation that the patient is unable to achieve remission with splenectomy unless the patient is not a candidate for surgery OR 2. In patients diagnosed with cold AIHA or cold agglutinin disease
RUZURGI

MEDICATION(S)
RUZURGI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Repetitive Nerve Stimulation (RNS) or anti-P/Q type voltage-gated calcium channel antibody test. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist

COVERAGE DURATION
Initial approval will be approved for 3 months. Reauthorization will be approved for 12 months.

OTHER CRITERIA
Initial authorization (all of the following must be met): 1. Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND 2. Clinical symptoms of LEMS, including dyspnea or functionally significant muscle weakness interfere with daily activities. AND 3. Patient has been evaluated for malignancy and treated for malignancy if present. Note: LEMS symptoms associated with malignancy may resolve after treatment directed at malignancy. AND 4. Documented trial and failure of at least one month, intolerance, or contraindication to pyridostigmine
Reauthorization: Documentation of a positive response to therapy such as improvement or stabilization of muscle weakness from baseline
MEDICATION(S)
JYNARQUE, SAMSCA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Hepatic Impairment, Anuria, Hypovolemia

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PREScriber RESTRICTION
Must be prescribed by, or in consultation with, a nephrologist.

COVERAGE DURATION
Jynarque: Initial/reauth will be approved for 1 year. Samsca: auth will be approved for 30 days.

OTHER CRITERIA
For autosomal dominant polycystic kidney disease (ADPKD), Jynarque® may be covered when all of the following criteria must be met: 1. Diagnosis of ADPKD confirmed by the following: a. Patient with family history of known or suspected ADPKD: at least two cysts per kidney b. Patient without family history of known or suspected ADPKD: genetic confirmation or bilaterally enlarged kidneys with presence of cysts, 2. Confirmed diagnosis of rapidly progressing ADPKD by at least one of the following: a. eGFR decline of at least 5 mL/min/1.73 m2 per year over 1 year, b. eGFR decline of at least 2.5 mL/min/1.73 m2 per year over a period of 5 years, c. Total kidney volume increase of at least 5% per year confirmed by at least 3 repeated ultrasound or MRI measurements taken at least 6 months apart, 3. Patient does not have significant renal disease other than ADPKD (e.g., renal cancer, acute kidney injury). For hypervolemic and euvolemic hyponatremia, Samsca® may be covered when all of the following criteria are met: 1. One of the following: a. Serum sodium of less than 125 mEq/L, b. Less marked hyponatremia (less than 135 mEq/L),
but symptomatic, 2. Evidence that initiation and re-initiation of therapy will be in a hospital setting where serum sodium can be monitored closely, 3. Patient does not have an urgent need to raise serum sodium acutely (e.g., acute/transient hyponatremia associated with head trauma)
MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 3 months and reauthorization will be approved for 1 year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Diagnosis of endogenous Cushing's Disease AND 2. Documentation of one of the following: a. Patient has failed pituitary surgery OR b. Patient is not a candidate for surgery. Reauthorization requires documentation of positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).
MEDICATION(S)
SIMVASTATIN 80 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Documentation demonstrating that patient has been maintained on simvastatin 80 mg for 12 months or more without evidence of muscle toxicity.
SOMAVERT

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Diagnosis of acromegaly, 2. Documentation of inadequate response to, or that patient is not a candidate for, one of the following treatment options: a. Surgery, b. Radiation therapy, or c. Dopamine agonist (e.g., bromocriptine, cabergoline) therapy, AND 3. Documentation of trial and failure, intolerance or contraindication to octreotide injection therapy. Reauthorization requires documentation of a positive response to therapy, such as a decrease or normalization of insulin like growth factor (IGF)-1.
SPRIX

MEDICATION(S)
KETOROLAC 15.75 MG NASAL SPRAY, SPRIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months

OTHER CRITERIA
Initial authorization: For short-term pain: 1. The patient is being treated for acute pain, 2. Documented trial and failure, intolerance or contraindication to two formulary generic nonsteroidal anti-inflammatory drugs.
STRENSIQ

MEDICATION(S)
STRENSIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Total serum alkaline phosphatase (ALP), current patient weight. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist, medical geneticist, or bone and mineral specialist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
Initial authorization: Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia confirmed by ALL of the following criteria: 1. Patient less than or equal to 18 at age of onset of disease AND 2. One of the following: a. Confirmation of tissue-nonspecific alkaline phosphatase (TNALPL or ALPL) gene mutation: OR b. Total serum alkaline phosphatase (ALP) below the lower limit of normal for age AND Plasma pyridoxal-5'-phosphate (PLP) above the upper limit. Note: Plasma PLP should not be measured while the member is receiving pyridoxine treatment AND 3. One or more of the following HPP- related findings: a. Radiographic evidence of hypophosphatasia (HPP) (eg. skeletal abnormalities) b. History or presence of non-traumatic fracture or delayed fracture healing c. Nephrocalcinosis or history of elevated serum calcium d. Functional craniosynostosis (early fusion of skull bones which may sometimes result in increased cranial pressure) e. Respiratory compromise or rachitic chest deformity f. Vitamin B6- responsive seizures g. Failure to thrive.
Reauthorization: Documentation of response to therapy with either improvement in respiratory status, skeletal manifestations or growth (in pediatric patients).
SUBLINGUAL IMMUNOTHERAPY

MEDICATION(S)
GRASTEK, ORALAIR, RAGWITEK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist or other physician currently providing subcutaneous immunotherapy to patients in their practice.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For treatment with sublingual immunotherapy, patients must meet all the following for initial authorization: 1. Diagnosis of allergic rhinitis, with or without conjunctivitis AND 2. Documentation that member remains symptomatic despite treatment with at least two conventional formulary allergy medications (e.g. levocetirizine, fluticasone nasal spray) AND 3. Documentation that the sublingual immunotherapy will begin 12 to 14 weeks before the expected onset of grass pollen season according to the respective FDA labels. AND 4. Documentation of a positive skin test to the relevant perennial aeroallergen AND 5. No other allergens are being treated concurrently with subcutaneous immunotherapy. Reauthorization requires documentation of consistent use of medication during treatment period for allergy season previously approved for coverage.
SUNOSI

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Idiopathic central nervous system hypersomnia

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. Full nocturnal polysomnogram and a multiple sleep latency test.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by a sleep specialist, neurologist, pulmonologist, or psychiatrist

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Initial Authorization: For Narcolepsy: 1. Diagnosis of narcolepsy as confirmed by sleep study or cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay) AND 2. 3-month trial and failure, intolerance or contraindication to both of the following: a) Stimulant (i.e. amphetamine, methylphenidate) b) Modafinil or Armodafinil. For Obstructive Sleep Apnea (OSA): 1. Diagnosis of OSA as confirmed by sleep study 2. Failure of a 3-month trial, intolerance or contraindication of armodafinil or modafinil. Reauthorization requires documentation that treatment has been effective.
MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients that require the use of drugs known to alter gastrointestinal motility (i.e. GI anticholinergics, metoclopramide). Patients with a confirmed diagnosis of gastroparesis.

REQUIRED MEDICAL INFORMATION
HbA1c. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an endocrinologist or credentialed diabetic specialist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Initial authorization: 1. Patient is an insulin dependent diabetic AND 2. Patient's HbA1c is greater than or equal to 7% and is less than or equal to 9% AND 3. Documentation of the failure of achieving optimal glycemic control despite multiple titrations and adjustments with various basal and bolus insulin dosing regimens. Reauthorization requires that the HbA1c remains less than or equal to 9%.
MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with a neurologist.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
1. Documentation of trial and failure, contraindication, or intolerance to clobazam tablets or suspension, AND 2. Documentation of trial and failure, contraindication, or intolerance to one (1) alternative generic formulary agent (e.g., valproic acid, lamotrigine, topiramate, felbamate).
MEDICATION(S)
SYNAREL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Endometriosis: auth approved for 6 months. CPP: initial/re-auth approved for one year

OTHER CRITERIA
For endometriosis all of the following criteria must be met: 1. Documentation that other causes of gynecologic pain have been ruled out (e.g., irritable bowel syndrome, interstitial cystitis, urinary tract disorders) AND 2. Documentation of trial and failure, intolerance, or contraindication to leuprolide therapy with add-back progesterone. Reauthorization is not covered, as treatment is only recommended for up to 6 months for endometriosis. For central precocious puberty (CPP) all of the following criteria must be met: 1. Documentation of early onset of secondary sexual characteristics (age 8 years and under for females or 9 years and under for males), 2. Confirmation of diagnosis by one of the following: a. Pubertal response to a GnRH stimulation test, b. Pubertal level of basal luteinizing hormone (LH) levels, or c. Bone age advanced one year beyond the chronological age, AND 3. Documentation of trial and failure, intolerance, or contraindication to leuprolide therapy. Reauthorization for CPP requires: 1. Documentation of clinical response to treatment (e.g., pubertal slowing or decline, height velocity, bone age, LH, or estradiol and
testosterone level), and 2. Documentation that hormonal and clinical parameters are being monitored periodically during treatment to ensure adequate hormone suppression.
MEDICATION(S)
CLOVIQUE, TRIENTINE HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Cystinuria or rheumatoid arthritis

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a gastroenterologist, medical geneticist, or hepatologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, intolerance, or contraindication to penicillamine (Depen®)
TAFAMIDIS

MEDICATION(S)
VYNDAMAX, VYNDAQEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
May be approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be written by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis

COVERAGE DURATION
Initial authorization will be approved for 6 months, reauthorization will be approved for 1 year

OTHER CRITERIA
Initial authorization: 1. Documentation of genetic testing results for mutations of the transthyretin (TTR) gene (patient may have a genetic variation or be wild type) 2. Confirmation of amyloid deposits showing cardiac involvement by ONE of the following: a. A positive 99mTechnetium-Pyrophosphate (99mTc-PYP) scan b. A positive cardiac biopsy for ATTR amyloid c. A positive non-cardiac biopsy for ATTR amyloid and evidence of cardiac involvement by end-diastolic interventricular septal wall thickness greater than 12 mm (by echocardiogram or MRI) or suggestive cardiac MRI findings 3. Documentation that patient has a NYHA functional classification of I, II or III 4. Documentation of clinical signs or symptoms of cardiomyopathy and/or heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema, elevated BNP or NT-BNP levels) Reauthorization: 1. Documentation of a positive clinical response such as evidence of slowing of clinical decline, reduced number of cardiovascular related hospitalizations, improvement or
stabilization of the 6-minute walk test or improvement or stabilization in the KCCQ-OS
MEDICATION(S)
TAVALISSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Recent platelet counts. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an oncologist or hematologist.

COVERAGE DURATION
Initial authorization will be approved for 3 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Diagnosis of chronic immune thrombocytopenia (ITP), 2. Platelet count of less than 30,000 per microliter, and 3. Inadequate response to at least TWO of the following therapies: a. Corticosteroids b. Immunoglobulins c. Splenectomy d. Thrombopoietin receptor agonists e. Rituximab. Reauthorization requires documentation of an improvement in platelet count to at least 50,000 per microliter.
TEGSEDI

MEDICATION(S)
TEGSEDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Platelet count less than 100 x 10^9 per liter

REQUIRED MEDICAL INFORMATION
Genetic test results (TTR gene testing), baseline Neuropathy Impairment Score (NIS), baseline Norfolk Quality of Life Diabetic Neuropathy Questionnaire (Norfolk QOL-DN) score. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist or a provider who specializes in the treatment of amyloidosis.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Initial authorization: 1. Confirmed diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR) with documentation of a pathogenic TTR mutation, AND 2. Demonstrate at least two (2) symptoms consistent with polyneuropathy of hATTR amyloidosis (e.g. peripheral sensorimotor polyneuropathy and autonomic neuropathy symptoms). Reauthorization requires documentation of response to therapy such as an improvement or stabilization from baseline based on an objective measurement (e.g. NIS or Norfolk QOL-DN).
TESTOSTERONE REPLACEMENT THERAPY

MEDICATION(S)
ANDRODERM, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Use exclusively for improvement of sexual signs and symptoms (e.g., decreased libido, sexual dysfunction)

REQUIRED MEDICAL INFORMATION
Testosterone levels. For initiation of treatment, a prior authorization form and clinical documentation supporting the request are required. For continuation of therapy, provider attestation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for adults 18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved until no longer eligible with the plan

OTHER CRITERIA
For patients established on testosterone replacement therapy and requesting use of a different testosterone replacement product than currently established on: Documented trial and failure of generic topical testosterone 1%. Failure is defined as inability to reach therapeutic levels or fluctuations in levels resulting in symptoms. For initiation of testosterone replacement therapy, all of the following criteria must be met: 1. Diagnosis of primary or secondary (hypogonadatropic) hypogonadism, AND 2. One of the following confirmatory laboratory values, taken before 11 am (or within 3 hours of waking for shift-workers) on different days without acute illness/stress, according to the local laboratory’s lower limit of normal (if available) or levels according to the listed values below: a. At least two (2) serum total testosterone levels less than 264 ng/dL (9.2 nmol/L), b. At least two (2) free testosterone levels less than 2 ng/dL (20 pg/mL), c. At least one (1) serum total testosterone level less than 264 ng/dL (9.2 nmol/L), AND one (1) free
testosterone levels less than 2 ng/ dL (20 pg/mL). Serum total testosterone level and free testosterone level must be taken on different days. 2. Documentation of trial and failure, contraindication or intolerance to generic topical testosterone 1% gel. Failure is defined as inability to reach therapeutic levels or fluctuations in levels resulting in symptoms.
THERAPEUTIC IMMUNOMODULATORS

MEDICATION(S)
COSENTYX (2 SYRINGES), COSENTYX PEN, COSENTYX PEN (2 PENS), COSENTYX SYRINGE, ENBREL, ENBREL MINI, ENBREL SURECLICK, HUMIRA, HUMIRA PEDIATRIC CROHN’S, HUMIRA PEN, HUMIRA PEN CROHN’S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN’S, HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN’S-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS, RINVOQ, SKYRIZI (2 SYRINGES) KIT, STELARA 45 MG/0.5 ML SYRINGE, STELARA 90 MG/ML SYRINGE, TREMFYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient is currently being treated with another therapeutic immunomodulator

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan

OTHER CRITERIA
For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency), AND 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator, OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, AND 2. Documentation of trial and failure,
intolerance, or contraindication to one conventional therapy prerequisite for the requested indication (see notes below), AND 3. One of the following: a. Patient is not currently being treated with another biologic immunomodulator, OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent. Notes: Use of ONE conventional agent prerequisite is required for diagnoses of psoriatic arthritis, plaque psoriasis, rheumatoid arthritis, or juvenile idiopathic arthritis. No prerequisites are required for diagnoses of ankylosing spondylitis, Crohn’s disease, ulcerative colitis, hidradenitis suppurativa, or uveitis. Formulary conventional agents for rheumatoid arthritis, juvenile idiopathic arthritis, or psoriatic arthritis include methotrexate, hydroxychloroquine, sulfasalazine, minocycline, or leflunomide. Formulary conventional topical or systemic agents for plaque psoriasis include topical corticosteroids, tazarotene, cyclosporine, calcipotriene, methotrexate, tacrolimus, pimecrolimus, or acitretin.
MEDICATION(S)
THIOLA, THIOLA EC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
24-hour urine collection with urinary cysteine levels. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a nephrologist or urologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
For initial authorization all of the following criteria must be met: 1. Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 500 mg/day, AND 2. Documented trial, failure, intolerance or contraindication to penicillamine (Depen). Reauthorization requires documentation of urine cysteine concentration less than 300 mg/L or reduction in production of cysteine stones.
MEDICATION(S)
TOPIRAMATE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist for seizure disorder.

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
For seizure disorder: Documentation of trial and failure, intolerance, or contraindication to topiramate immediate-release and one additional formulary anti-epileptic medication (e.g., valproic acid, levetiracetam, lamotrigine). For migraine prophylaxis: Documentation of trial and failure, intolerance, or contraindication to topiramate immediate-release and one additional formulary agent used for migraine prophylaxis (e.g., divalproex, propranolol, metoprolol).
**TYSABRI**

**MEDICATION(S)**
TYSABRI

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Use of Tysabri in combination with other disease modifying therapy to treat patients with multiple sclerosis will not be covered. In Crohn’s disease, the use of Tysabri in combination with immunosuppressants or inhibitors of TNF-alpha will not be covered.

**REQUIRED MEDICAL INFORMATION**
Anti-JCV antibody. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, a neurologist or gastroenterologist.

**COVERAGE DURATION**
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

**OTHER CRITERIA**
For multiple sclerosis: 1. Diagnosis of relapsing remitting multiple sclerosis AND 2. Documentation of trial, failure, or intolerance to primary therapy with at least two of the following disease modifying therapies, or medical rationale why these therapies cannot be tried: 1) interferon beta-1a (Avonex, Rebif), 2) peginterferon beta-1a (Plegridy), 3) Interferon-beta 1b (Betaseron), 4) dimethyl fumarate (Tecfidera), 5) glatiramer acetate (Copaxone), 6) Teriflunomide (Aubagio), or 7) Fingolimod (Gilenya) AND 3. Negative anti-JCV antibody status. If anti-JCV antibody positive, the patient must meet the following criteria: a. Confirmation patient has not used any of the following immunosuppressants agents: mitoxantrone, azathioprine, methotrexate, cyclophosphamide, or mycophenolate mofetil AND b. Medical rationale is provided for continued use despite increased risk of developing progressive multifocal leukoencephalopathy.
For Crohn’s disease: 1. Diagnosis of moderate to severe Crohn’s disease AND 2. Documentation of trial, failure, intolerance, or lack of response to a formulary TNF-alpha inhibitor (e.g. infliximab or adalimumab) indicated for Crohn’s AND 3. Negative anti-JCV antibody status. If anti-JCV antibody positive, the patient must meet the following criteria: a. Confirmation patient has not used any of the following immunosuppressants agents: mitoxantrone, azathioprine, methotrexate, cyclophosphamide, or mycophenolate mofetil AND b. Medical rationale is provided for continued use despite increased risk of developing PML. Reauthorization: Documentation of response to therapy must be provided.
VALTOCO

MEDICATION(S)
VALTOCO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist

COVERAGE DURATION
Authorization will be approved until no longer eligible with the plan

OTHER CRITERIA
N/A
MEDICATION(S)
VASCEPA

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Reduction of cardiovascular events in patients with hypertriglyceridemia

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Triglyceride level. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGERESTRICTION
N/A

PRESCRIBERRESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For the treatment of hypertriglyceridemia, all of the following criteria must be met: 1. A triglyceride level within the past 6 months that is greater than or equal to 500 mg/dL, AND 2. A two-month trial and failure, intolerance, or contraindication to a formulary agent to treat very high triglycerides (such as fenofibrate). Reauthorization requires documentation of reduction in triglyceride levels. For reducing risk of cardiovascular events, all of the following criteria must be met: 1. Patient must meet one of the following: a. Aged 45 years or older with established cardiovascular disease (i.e., coronary artery disease, cerebrovascular or carotid disease, or peripheral arterial disease), OR b. Aged 50 years or older with diabetes mellitus and at least one additional risk factor (e.g., smoker, hypertension, low HDL-cholesterol, retinopathy), AND 2. A triglyceride level within the past 6 months of 150 to 499 mg/dL, AND 3. Current use of statin therapy for at least 4 weeks or intolerance/contraindication to their use, AND 4. Documented LDL-cholesterol between 40 and 100 mg/dL.
VIBERZI

MEDICATION(S)
VIBERZI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients without a gallbladder.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a gastroenterologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For irritable bowel disease with diarrhea (IBS-D): 1. Confirmed diagnosis by a gastroenterologist, AND 2. Documentation of trial and failure, contraindication, or intolerance to loperamide. Reauthorization requires documentation of response to treatment, defined as improvement in stool consistency and abdominal pain.
VMAT-2 INHIBITORS

MEDICATION(S)
AUSTEDO, INGREZZA, INGREZZA INITIATION PACK, TETRABENAZINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Abnormal Involuntary Movement Scale (AIMS) score. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a neurologist or psychiatrist

COVERAGE DURATION
Initial authorization will be approved for 3 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
For chorea associated with Huntington disease, the following criteria must be met: 1. Diagnosis of Huntington disease as defined by all of the following: a. DNA testing showing CAG expansion of more than 37, b. Family history (if known), and c. Classic presentation (choreiform movements, psychiatric problems, and dementia). Reauthorization requires documentation of response to therapy (e.g., improved function through reduction of choreiform movements). For tardive dyskinesia, all of the following criteria must be met: 1. Diagnosis of tardive dyskinesia secondary to therapy with a dopamine receptor blocking agent, 2. Documentation of the patient's baseline Abnormal Involuntary Movement Scale (AIMS) score, 3. Documentation of moderate to severe tardive dyskinesia, as defined by one of the following AIMS scores: a. Total score on items 1-7 of at least 8, b. Score of 3 or 4 on item 8 (severity of abnormal movement overall): AND 4. Documentation of a two-month trial and failure, contraindication, or intolerance to clonazepam or amantadine. Reauthorization requires documentation of positive clinical response to therapy, as
demonstrated by improvement in AIMS.
WAKIX

MEDICATION(S)
WAKIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Idiopathic central nervous system hypersomnia

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. Full nocturnal polysomnogram and a multiple sleep latency test.

AGE RESTRICTION
Approved for patients 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a sleep specialist, neurologist, pulmonologist, or psychiatrist

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Initial Authorization: For Narcolepsy: 1. Diagnosis of narcolepsy as confirmed by one of the following: a. The patient has a Multiple Sleep Latency Test (MSLT) showing both of the following: i. Mean sleep latency of 8 minutes or less AND ii. Two (2) or more early-onset rapid eye movement (REM) sleep test periods (SOREMPs) b. The patient has a Multiple Sleep Latency Test (MSLT) showing all of the following: i. Mean sleep latency of 8 minutes or less AND ii. One (1) SOREMP AND iii. Additionally one SOREMP (within approximately 15 minutes) on a polysomnography the night preceding the MSLT, with the polysomnography ruling out non-narcolepsy causes of excessive daytime sleepiness (EDS) c. The patient has low orexin/hypocretin levels on a cerebrospinal fluid (CSF) assay (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay) 2. Documentation of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months 3. Documentation of a three (3)-month trial and failure, incomplete response, intolerance, or contraindication to both of the
following: a) Stimulant (e.g., amphetamine, methylphenidate) b) Modafinil or armodafinil. Reauthorization: Documentation of successful response to the medication, such as a reduction in symptoms of excessive daytime sleepiness
MEDICATION(S)
COLESEVELAM HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Monotherapy for the treatment of type 2 diabetes and triglyceride level greater than 500 mg/dL

REQUIRED MEDICAL INFORMATION
HbA1c, triglyceride level. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan.

OTHER CRITERIA
Primary Hyperlipidemia: 1. Documented intolerance or contraindication to a generic, high-intensity statin (i.e. atorvastatin 80mg) AND 2. Documented trial, intolerance or contraindication to cholestyramine AND 3. TG less than 500mg/dL (absolute contraindication if over 500mg/dL). Type 2 diabetes 1. Documentation of trial and failure, contraindication or intolerance to metformin therapy, up to a maximum effective dose of 2000 mg/day AND 2. Documented trial and failure to one of the following medication classes, or intolerance/contraindication to all classes listed below: a. Sulfonylurea (e.g., glimepiride), b. Thiazolidinedione (e.g., pioglitazone), c. Sodium-glucose co-transporter 2 (SGLT2) inhibitor (e.g., empagliflozin (Jardiance®), or d. Glucagon-like peptide-1 (GLP-1) receptor agonist (e.g., liraglutide, exenatide, semaglutide) AND 3. A documented HbA1c, obtained within the last six months, that is greater than or equal to 7% and less than or equal to 10%. Reauthorization requires documentation of HbA1c less than or equal to 9% (taken within previous 6 months).
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
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a dermatologist, gastroenterologist, or rheumatologist

COVERAGE DURATION
Initial auth approved for 1 year. Reauth will be approved until no longer eligible with the plan

OTHER CRITERIA
For patients already established on the requested therapy: 1. Documentation of response to therapy (i.e. slowing of disease progression or decrease in symptom severity and/or frequency) and 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator. For patients being initiated on therapy, all of the following criteria must be met: 1. Patient must have an FDA labeled indication for the requested agent, 2. One of the following: a. Patient is not currently being treated with another biologic immunomodulator OR b. Patient is currently being treated with another biologic immunomodulator AND will discontinue the other biologic immunomodulator prior to starting the requested agent, 3. Documentation of trial and failure, intolerance, or contraindication to preferred biologic agents, as follows: For Xeljanz/Xeljanz XR: Use of TWO preferred biologics (Enbrel, Humira, Rinvoq) is required for diagnoses of rheumatoid arthritis. Use of TWO preferred biologics
(Cosentyx, Enbrel, Humira, or Stelara) is required for diagnosis of psoriatic arthritis. For Xeljanz/Xeljanz XR: Use of ONE preferred biologic (Humira or Stelara) is required for diagnosis of ulcerative colitis.
\textbf{MEDICATION(S)}
XERMELO

\textbf{PA INDICATION INDICATOR}
1 - All FDA-Approved Indications

\textbf{OFF LABEL USES}
N/A

\textbf{EXCLUSION CRITERIA}
N/A

\textbf{REQUIRED MEDICAL INFORMATION}
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

\textbf{AGE RESTRICTION}
N/A

\textbf{PRESCRIBER RESTRICTION}
Must be prescribed by, or in consultation with, an oncologist or hematologist.

\textbf{COVERAGE DURATION}
Initial authorization and reauthorization will be approved for one year

\textbf{OTHER CRITERIA}
All of the following criteria must be met: 1. Diagnosis of carcinoid syndrome diarrhea 2. Patient is experiencing four (4) or more bowel movements per day, despite use of long-acting octreotide therapy (e.g., octreotide LAR (Sandostatin LAR), lanreotide (Somatuline®) for at least three (3) months 3. Documentation of failure to the use of short-acting octreotide (Sandostatin) for breakthrough symptoms. Failure is defined as continuing to experience four (4) or more bowel movements per day despite daily use 4. Documentation that long-acting octreotide therapy will be used in combination with the requested medication. Reauthorization will require documentation of response to therapy, defined as a reduction in frequency of bowel movements.
**MEDICATION(S)**
XIFAXAN

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
Traveler's diarrhea: approved for 12 years of age and older. Hepatic Encephalopathy and irritable bowel syndrome with diarrhea (IBS-D): approved for 18 years of age and older

**PRESCRIBER RESTRICTION**
For irritable bowel syndrome with diarrhea (IBS-D): Must be prescribed by, or in consultation with, a gastroenterologist.

**COVERAGE DURATION**
Hepatic encephalopathy: 1 year. Traveler’s diarrhea: 3 days. IBS-D: 14 days

**OTHER CRITERIA**
For traveler's diarrhea (200 mg tablets): 1. Diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli, AND 2. Documentation that the patient does not have a fever or blood in the stool. For hepatic encephalopathy (HE) (550 mg tablets): Documentation of trial and failure, contraindication or intolerance to lactulose. For irritable bowel syndrome with diarrhea (IBS-D) (550 mg tablets) with or without small intestinal bacterial growth (SIBO): 1. Documentation of trial and failure, contraindication, or intolerance to opioid mu receptor agonists [e.g. loperamide (Imodium)], AND 2. Diagnosis of IBS-D by a gastroenterologist. Reauthorization in IBS-D requires documentation of initial response to treatment with rifaximin and recurrence of IBS-D symptoms.
MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For asthma only: IgE for initiation, Asthma Control Test (ACT) and/or Asthma Control Questionnaire (ACQ) scores. For initiation of treatment, a prior authorization form and relevant chart notes documenting drug rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Asthma: 6 years of age and older. Urticaria: 12 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For asthma, must meet all of the following criteria: 1. Diagnosis of moderate or severe persistent allergic asthma, 2. IgE baseline levels greater than 30 IU/ml, 3. Positive skin test to common perennial aeroallergens, 4. Documentation of at least a 90-day trial of a combination of a high-dose inhaled corticosteroid and a long-acting inhaled beta2-agonist unless there is intolerance or contraindication to the medications, 5. Documentation of inadequate asthma control defined as one of the following: a. Asthma Control Test (ACT) score less than 20 or Asthma Control Questionnaire (ACQ) score greater than 1.5, b. At least two exacerbations requiring oral systemic corticosteroids in the last 12 months, or c. At least one exacerbation requiring hospitalization. Initial reauthorization for asthma will require documentation of response to therapy with at least one of the following: 1. Improvement in ACT or ACQ score, 2. Reduction in number of asthma exacerbations requiring oral systemic corticosteroids or hospitalization, or 3. Decrease
in utilization of rescue medications (This may be verified by pharmacy claims information). Subsequent reauthorization requires documentation of continued benefit from therapy. For chronic idiopathic urticaria, must meet all of the following criteria: 1. Documentation that secondary causes of urticaria (e.g., offending allergens, physical contact, etc.) have been ruled out, 2. Trial and failure, intolerance, or contraindication to levocetirizine, and 3. Trial and failure, intolerance, or contraindication to one of the following: montelukast, famotidine or ranitidine. Reauthorization will require documentation of response to therapy (e.g. reduction in flares or oral steroid dose).
XYREM

MEDICATION(S)
XYREM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Full nocturnal polysomnogram and a multiple sleep latency test (for diagnosis of narcolepsy). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a sleep specialist or neurologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
For Narcolepsy: 1. Full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes, AND 2. No other polysomnographic reasons to explain sleepiness, AND 3. Documentation of trial and failure, contraindication, or intolerance to modafinil AND armodafinil, unless the patient is diagnosed with cataplexy. Reauthorization requires documentation that treatment has been effective.