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)**
FLUOROURACIL 0.5% CREAM, 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.
ADEMPAS

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Adempas is contraindicated during pregnancy.

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
Prescribed by or in consultation with a Pulmonologist or Cardiologist.

COVERAGE DURATION
Initial prior auth will be approved for 6 months. Reauth will be approved for 1 yr.

OTHER CRITERIA
For the treatment of Pulmonary Arterial Hypertension, the following criteria must be documented: 1. Catheterization-proven diagnosis of Pulmonary Arterial Hypertension 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.
**MEDICATION(S)**
ARALAST NP, GLASSIA, PROLASTIN C 1,000 MG VIAL, 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 for 6 months. Reauthorization will be 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.
ALZHEIMERS DRUG

MEDICATION(S)
MEMANTINE HCL ER, NAMENDA XR TITRATION PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of AD as defined by DSM-IV criteria and MMSE OR SLUMS exam. 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
Not approved for pediatrics.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization 3 months, up to 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. Patients should have documented in their medical record a diagnosis of moderate to severe dementia of the Alzheimer’s type according to the criteria of the Diagnostic and Statistical Manual 5th ed. (American Psychiatric Association, 2013). 2. Have moderate to severe Alzheimer’s dementia as defined by a Mini-Mental State Exam (MMSE) or Saint-Louis University Mental Status (SLUMS) Exam of less than 20. 3. Documented trial, failure, or contraindication to memantine tablets. Ongoing authorization will require documentation of stabilization of clinical disease from the medication.
MEDICATION(S)
AMPHOTERICIN B 50 MG VIAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a Infectious disease specialist.

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

OTHER CRITERIA
NA
ANTI-CANCER AGENTS

MEDICATION(S)
ABIRATERONE ACETATE, AFINITOR, AFINITOR DISPERZ, ALECENSA, ALUNBRIG, BALVERSA, BEXAROTENE, BOSULIF, BRAFTOVI, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, ERLOTINIB HCL, FARYDAK, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, LENVIMA, LONSURF, LORBRENA, LYNPARZA, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, NUBEQA, ODOMZO, PIQRAY, POMALYST, REVLIMID, RUBRACA, RYDAPT, SPRYCEL, STIVARGA, SUTENT, SYLATRON, SYLATRON 4-PACK, SYNRIBO, TAFINLAR, TAGRISSO, TALZENNA, TARGRETIN 1% GEL, TASIGNA, TIBSOVO, TRETINOIN 10 MG CAPSULE, TYKERB, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZORTRESS, 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
N/A
ANTIDEPRESSANTS

MEDICATION(S)
FETZIMA, TRINTELLIX, VIIBRYD 10 MG TABLET, VIIBRYD 10-20 MG STARTER PACK, VIIBRYD 20 MG TABLET, VIIBRYD 40 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
N/A

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

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to two formulary, generic SSRIs or SNRIs (e.g., citalopram, sertraline, paroxetine, venlafaxine, duloxetine)
ANTIEPILEPTIC AGENTS

**MEDICATION(S)**
APTIOM, BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET, 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, VIMPAT 10 MG/ML SOLUTION, VIMPAT 100 MG TABLET, VIMPAT 150 MG TABLET, VIMPAT 200 MG TABLET, VIMPAT 50 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.

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

**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, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, 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 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.
**MEDICATION(S)**
ARISTADA ER 1064 MG/3.9 ML SYR, INVEGA SUSTENNA, INVEGA TRINZA, LATUDA, PALIPERIDONE ER, REXULTI, SAPHRIS, 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**
Initial authorization and reauthorization will be approved for one year.

**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) AND 2) Documented trial, failure, intolerance or contraindication to two formulary antipsychotics used for this indication (e.g., quetiapine extended-release, aripiprazole). For schizophrenia or bipolar disorder: Documented trial, failure, intolerance or contraindication to two formulary, generic antipsychotics (e.g., quetiapine immediate-release, olanzapine, ziprasidone, risperidone).
MEDICATION(S)
APOKYN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with any of the 5HT3 receptor antagonists-(eg. 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 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 adults and children 12 years and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial auth will be approved for 6 months. Reauth will be approved for 1 yr.

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.
**ARISTADA**

**MEDICATION(S)**
ARISTADA ER 441 MG/1.6 ML SYRN, ARISTADA ER 662 MG/2.4 ML SYRN, ARISTADA ER 882 MG/3.2 ML SYRN

**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 generic formulary medications indicated for the treatment of schizophrenia (e.g., olanzapine, risperidone, ziprasidone).
MEDICATION(S)
AUBAGIO, GILENYA 0.5 MG CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
The use of Aubagio in combination with other multiple sclerosis disease modifying therapy has not been studied and concomitant use with other MS medications will not be covered.

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
Teriflunomide must be prescribed by or in consultation with a Neurologist.

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

OTHER CRITERIA
Documentation of trial and failure, contraindication, intolerance to 1 of the following 5 drug therapies: interferon beta-1a (Avonex), interferon beta-1a (Rebif), interferon beta-1a (Plegridy), glatiramer acetate (Copaxone), or dimethyl fumarate (Tecfidera), OR medical rationale why primary therapies cannot be tried.
BARBITURATES

MEDICATION(S)
PHENOBARBITAL 16.2 MG TABLET, PHENOBARBITAL 20 MG/5 ML ELIX, PHENOBARBITAL 20 MG/5 ML SOLN, PHENOBARBITAL 30 MG TABLET, PHENOBARBITAL 32.4 MG TABLET, PHENOBARBITAL 64.8 MG TABLET, PHENOBARBITAL 97.2 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
N/A

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

OTHER CRITERIA
1. Member is less than 65 years of age OR 2. For use for in epilepsy: documented trial, failure, contraindication or intolerance to at least two formulary anticonvulsant agents or medical rationale is provided why formulary anticonvulsants are not indicated. AND for all FDA-approved indications, prescribing provider indicates that medical benefits exceed the risks associated with these medications.
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), 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 mofetil, hydroxychloroquine, chloroquine, cyclophosphamide. Reauthorization requires: 1. Documentation of successful response to the medication AND 2. Documentation that oral corticosteroid use is stable or decreased.
MEDICATION(S)
BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET,
BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET, 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
Documented trial, failure, contraindication or intolerance to generic levetiracetam tablets and generic
levetiracetam oral solution.
MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN 50-325

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

PRESCRIBER RESTRICTION
NA

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

OTHER CRITERIA
1. Member is less than 65 years of age. OR 2. Documentation that the risks of the medication (e.g., drowsiness, dizziness, confusion, physical dependence) have been discussed with the patient, including that these risks increase with age. AND 3. Documentation that the provider feels this medication is appropriate for the patient’s age despite the risks outlined above. Reauthorization requires: 1. Documentation that the patient is responding well to therapy without side effects AND 2. Documentation that the risks of the medication have been discussed at least annually with the patient and the provider and patient both feel continuation of therapy is medically necessary despite risks.
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 clinical documentation supporting the request are required. For continuation of therapy, provider attestation 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
CFTR MODULATORS

MEDICATION(S)
KALYDECO 150 MG TABLET, KALYDECO 50 MG GRANULES PACKET, KALYDECO 75 MG GRANULES PACKET, ORKAMBI

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.
CHENODAL

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 use in cerebrotendinous xanthomatosis, must be prescribed by, or in consultation with, a Genetics or Metabolism Specialist. For use for gallstone dissolution, must be prescribed by a Gastroenterologist.

COVERAGE DURATION
Initial 6 months. Reauthorization for 1 year. A total of 2 years for the diagnosis of gallstones.

OTHER CRITERIA
For use in gallstone dissolution: 1. Documentation that the patient is not a candidate for surgery, AND 2. Documentation of trial and failure, contraindication or intolerance to ursodiol
CORLANOR

MEDICATION(S)
CORLANOR

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 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), AND 2. Documentation that other causes of sinus tachycardia have been ruled out (e.g., thyroid disease, medications or drugs).
**MEDICATION(S)**
DALFAMPRIDINE ER

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

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
25-foot walk 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 auth will be for 6 months and reauthorization will be approved for 1 yr.

**OTHER CRITERIA**
Initial authorization requires all of the following: 1. Diagnosis of multiple sclerosis, 2. Documentation of baseline 25-foot walk test showing that patient has difficulty walking, 3. Documentation of one of the following: a. Patient has an expanded disability status scale (EDSS) score less than or equal to 7, or b. Patient is not restricted to using a wheelchair (if EDSS is not measured). Reauthorization requires all of the following: 1. Documentation that mobility has improved, defined as an improvement in 25 foot walk test, 2. Documentation of one of the following: a. Patient has an EDSS score less than or equal to 7, or b. Patient is not restricted to using a wheelchair (if EDSS is not measured)
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).
DAYTRAN

**MEDICATION(S)**
DAYTRAN

**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 members 6 years of age and older.

**PRESCRIBER RESTRICTION**
N/A

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

**OTHER CRITERIA**
1. Documentation of trial and failure, contraindication or intolerance to two (2) formulary long-acting stimulant agents for ADHD (e.g., generic Adderall, generic Dexedrine, generic Ritalin, generic Ritalin SR, Adderall XR, Concerta, Metadate CD, Ritalin LA or Strattera). AND 2. Documentation or medical rationale why member cannot use a formulary stimulant medication in chewable or solution form (e.g., Methylphenidate Chewable tablets or methylphenidate solution) if unable to swallow tablets/capsules. AND 3. For members 65 years and older, documentation that medical benefits exceeds the risks (drug dependence, hypertension, myocardial ischemia, agitation, insomnia and/or seizures associated with these medications) associated with these medications is needed.
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 6 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

**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).

**COVERAGE DURATION**
Initial auth will be approved for 6 months. Re-auth will be approved for 1 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.
MEDICATION(S)
DUZALLO 200-300 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Monotherapy for the treatment of hyperuricemia associated with gout.

REQUIRED MEDICAL INFORMATION
Serum uric acid 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
N/A

COVERAGE DURATION
Initial authorization for 6 months. Reauthorization for 12 months.

OTHER CRITERIA
1) Documented clinical diagnosis of gout, AND 2) Documented serum uric acid levels greater than 6 mg/dL after at least 3 months of therapy with a xanthine oxidase inhibitor (e.g., allopurinol or febuxostat (Uloric)), AND 3) Documented trial, failure, contraindication or intolerance to probenecid in combination with a xanthine oxidase inhibitor. Clinical failure is defined as the inability to achieve serum uric acid levels of less than 6 mg/dL after at least three months of combination therapy. Reauthorization requires documented response to therapy as defined by a reduction in occurrence of gout flares, tophi reduction, or serum uric acid levels maintained below 6 mg/dL.
**EGRIFTA**

**MEDICATION(S)**
EGRIFTA

**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 auth and reauth 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)
TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

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
ELIDEL Cream 1% is approvable for adults and children 2 years of age and older. Tacrolimus ointment 0.03% is approvable for adults and children 2 years of age and older. Tacrolimus ointment 0.1% is approvable for adults and children 16 years of age and older.

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Documentation of trial and failure of and adequate treatment course (2 weeks) of two (2) topical corticosteroids. One of the agents should be a high potency corticosteroid (such as betamethasone dipropionate augmented ointment, clobetasol propionate cream or ointment, or halobetasol cream/ointment), unless member has a contraindication to corticosteroid therapy (such as location of atopic dermatitis).
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 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)
ENBREL

MEDICATION(S)
ENBREL, ENBREL SURECLICK

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 authorization and reauthorization will be approved for 6 months subject to criteria.
OTHER CRITERIA
For Rheumatoid arthritis: 1. Documentation or trial and failure of methotrexate. If tolerance or contraindication to methotrexate, then trial and failure of leflunomide. AND 2. Documentation that Enbrel will be used concurrently with a DMARD, such as methotrexate or leflunomide, unless medical rationale is provided to support monotherapy. For Polyarticular Juvenile Rheumatoid Arthritis: Documentation of trial and failure, intolerance, or contraindication to one DMARD (i.e. Methotrexate). For Psoriatic Arthritis: Documentation of trial and failure, intolerance, or contraindication to one DMARD (i.e. Methotrexate). For Ankylosing Spondylitis: Documentation of trial and failure, intolerance, or contraindication to two NSAIDs (i.e. naproxen, diclofenac). For Chronic Plaque Psoriasis: Documentation of trial and failure, intolerance, or contraindication to two conventional treatments such as topical glucocorticoids (i.e., fluocinide or clobetasol), calcipotriene, Tazorac, methotrexate, or acitretin. Reauthorization will require documentation of appropriate FDA approved dose and adequate response to the medication for all diagnosis.
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 prescribed 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
For initiation of treatment, a prior authorization form and accurate diagnosis or high-resolution computed tomography supporting the request are required. For continuation of therapy, provide attestation of successful response (clinician assessment or pulmonary function test) 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
Confirmed diagnosis of Idiopathic Pulmonary Fibrosis and presence of a histological pattern associated with usual interstitial pneumonia (UIP) on high-resolution computed tomography or lung biopsy.
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 an allergist.

COVERAGE DURATION
Initial auth will be approved for 6 months. Reauth will 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. 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.
FORTEO

MEDICATION(S)
FORTEO

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 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, orthopedist, gynecologist or rheumatologist.

COVERAGE DURATION
Initial approval and renewal for 1 year. Total duration of Forteo 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
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. For all indications, documentation of response must be submitted in order for continued authorization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
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
**GNRH ANTAGONISTS**

**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 months

**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 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 300 MCG/ML VIAL, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL, EPOGEN 2,000 UNITS/ML VIAL, EPOGEN 20,000 UNITS/2 ML VIAL, EPOGEN 20,000 UNITS/ML VIAL, EPOGEN 3,000 UNITS/ML VIAL, EPOGEN 4,000 UNITS/ML VIAL, PROCRIT

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

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Patients with uncontrolled hypertension-darbepoetin alfa or erythropoietin is not indicated for treating patient with anemia induced from hepatic C therapy.

**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 will be for 3 months. Reauthorization will be for 3 months.
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 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 (CRF) i. Aranesp/Epogen/Procrit may be covered. b. Treatment of anemia due to chemotherapy in cancer and related neoplastic conditions (see exclusion criteria for non-covered indications). i. Aranesp/Epogen/Procrit may be used. ii. Must be secondary to myelosuppressive anticancer chemotherapy. iii. 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). i. Aranesp/Epogen/Procrit may be approved. ii. Must have 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 (Procrit, Epogen). ii. Documented endogenous serum erythropoietin level is less than or equal to 500 mIU/ml. iii. Zidovudine dose is less than or equal to 4200mg/week. e. Anemia associated with the treatment of specific chronic diseases with agents known to cause anemia [rheumatoid arthritis, regional enteritis (or Crohns Disease), and ulcerative colitis]: i. Coverage is for epoetin only (Procrit, Epogen). ii. Treatment may not be continued beyond 8 weeks after therapy with agent known to cause anemia is complete. f. Preoperative use in anemic patients scheduled for elective hip or knee surgery. i. Coverage is for epoetin only (Procrit, Epogen). ii. All of the following must be met. 1. Member must be scheduled to undergo elective hip or knee surgery. 2. Member has preoperative anemia with pretreatment HGB between 10 and 13 g/dL. 3. Member is expected to lose more than 2 units of blood. 4. Member has received an appropriate preoperative workup revealing that the anemia appears to be that of chronic disease. - Covered range during treatment: 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, baseline HCV RNA count, complete blood count, liver panel, renal function status, prior therapy and response are required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or providers specialized 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.
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. For all indications, documentation of response must be submitted in order for continued authorization.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial auth will be approved for 6 months. Reauth will be approved for 1 year.

OTHER CRITERIA
1. Member is blind. AND 2. Documented diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as characterized by: a. Distinct pattern of sleeping and waking that drifts by a consistent time period every night. b. History of periods of insomnia, excessive sleepiness, or both, which alternate with short asymptomatic periods. Reauthorization criteria: 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 on the recommendation of an endocrinologist.

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

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-I below 2.5 percentile 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: i. BMI less than 25: Peak GH less than/equal to 11.0 mcg/L ii. BMI 25-30: Peak GH less than/equal to 8.0 mcg/L iii. 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) Reauthorization: Requires evidence of improved quality of life, good tolerability and annual documentation of IGF-I levels with appropriate dosage adjustments. (GH requirements often decrease with age) 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, members retested, and have the following results: a. At least 2 other pituitary hormone deficiencies (i.e. TSH, ACTH, Gonadotropins, and ADH), AND two of the following: b. IGF-I less than 50th percentile for age/sex i. If IGF-I less than 2.5 percentile, no further testing is required. c. ITT with peak GH less than/equal to 5.0 mcg/L d. GHRH/Arg stim with low peak GH based on BMI: i. BMI less than 25: Peak GH less than/equal to 11.0 mcg/L ii. BMI 25-30: Peak GH less than/equal to 8.0 mcg/L iii. BMI greater than/equal to 30: Peak GH less than/equal to 4.0 mcg/L e. Glu stim with peak GH less than/equal to 3.0 mcg/L f. Arg stim with peak GH less than/equal to 0.4 mcg/L. Reauthorization: Requires evidence of improved quality of life, good tolerability and annual documentation of IGF-I levels with appropriate dosage adjustments (GH requirements often decrease with age). AIDS Wasting 1. Involuntary loss of at least 10% body weight AND 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. Authorization will be given for a maximum of 12 months. For Short Bowel Syndrome authorization will be given for a maximum of 4 weeks. Efficacy beyond 4 weeks has not been established.
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
Must be prescribed by an endocrinologist.

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)
JUXTAPID, 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. For all indications, documentation of response must be submitted in order for continued authorization.

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)
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 auth will be approved for 6 months and reauth will be approved for 1 yr.

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)
LIDODERM

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 for 1 year.

OTHER CRITERIA
Documented trial, failure, intolerance, or contraindication to gabapentin. Reauthorization will require documentation of response to therapy.
MEDICATION(S)
LUMIZYME

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
N/A
LYRICA

MEDICATION(S)
PREGABALIN

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
For postherpetic neuralgia: Documentation of trial (treatment course of at least 30 days) and failure, contraindication of intolerance to gabapentin. For fibromyalgia documentation of an adequate treatment course of at least 30 days with the following medication treatment options unless contraindicated or not tolerated: One TCA or SSRI or SNRI and Gabapentin.
MAVENCLAD

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)
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
18 years of age and older

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

COVERAGE DURATION
Initial and reauthorization will be approved for 1 month (7 days of treatment)

OTHER CRITERIA
1. Diagnosis of chronic liver disease
2. Platelet count of less than 50,000 platelets/L
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
MUSCULOSKELETAL DRUGS

MEDICATION(S)
CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 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
N/A

COVERAGE DURATION
Initial auth will be approved for 3 months. Reauth will be approved for one year.

OTHER CRITERIA
1. Member is under 65 years old OR 2. If over 65 years: a. Documentation that the risks of the medications (CNS depression) have been discussed with the patient, including that these risks increase with age. AND b. Documentation that the provider feels this medications is appropriate for the patient's age despite the risks outlined above. Reauthorization requires: 1. Documentation that the patient is responding well to therapy without side effects AND 2. If over 65 years, documentation that the risks of the medication have been discussed at least annually with the patient and the provider and the patient both feel continuation of therapy is medically necessary despite risks.
MEDICATION(S)
MYRBETRIQ

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. For all indications, documentation of response must be submitted in order for continued authorization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A
MEDICATION(S)
NORTHERA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization will be for 2 months. Reauthorization will be for 6 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.
**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): 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
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

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.
**OCTREOTIDE**

**MEDICATION(S)**
OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL

**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**
Safety and efficacy has not been established in the pediatric population.

**PRESCRIBER RESTRICTION**
N/A

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

**OTHER CRITERIA**
N/A
MEDICATION(S)
BANZEL, CLOBAZAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

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

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

OTHER CRITERIA
All of the following must be met: 1. Patient must have diagnosis of Lennox-Gastaut syndrome. 2. Documentation of trial and failure, contraindication or intolerance to at least two (2) alternative formulary generic antiepileptic medications. 3. For approval of clobazam (Onfi/Sympazan) in patients 65 years and older prescribing provider must indicate that medical benefits exceed the risks associated with this medication.
**ORAL ANTIDIABETIC AGENTS**

**MEDICATION(S)**
BYDUREON, BYETTA, OZEMPIC, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK

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

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
NA

**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**
NA

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial auth for 6 months and reauth approved 1 yr subject to effective response criteria.

**OTHER CRITERIA**
All the following criteria are required: 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 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%. Criteria for evaluation of effective response: Reauthorization requires that the HbA1c remains less than or equal to 9%.
ORENCIA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

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

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

OTHER CRITERIA
Documentation of trial, failure, intolerance, or contraindication to Simponi.
OSMOLEX ER

MEDICATION(S)
OSMOLEX 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, psychiatrist or expert in the treatment of movement disorders

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

MEDICATION(S)
OTEZLA 28 DAY STARTER PACK

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 adults 18 years of age and older.

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

COVERAGE DURATION
Initial authorization will be approved for 6 months. 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 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.
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 auth will be approved for 6 months. Reauth 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).
PCSK-9 INHIBITORS

MEDICATION(S)
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 auth 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. 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. 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 familial hypercholesterolemia (FH), 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. Reauthorization: Documentation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels.
MEDICATION(S)
PREVYMIS 240 MG TABLET, PREVYMIS 480 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
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)
PROLIA

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

MEDICATION(S)
MODAFINIL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIREDMEDICAL INFORMATION
Full nocturnal polysomnogram and a multiple sleep latency test (for diagnosis of narcolepsy and obstructive sleep apnea). 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 6 months. Reauth will be approved 1 yr subject to criteria.
OTHER CRITERIA
For Narcolepsy, all of the following criteria must be met: a. Established diagnosis of Narcolepsy from a sleep specialist. b. Full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes. c. No other polysomnographic reasons to explain sleepiness, d. For members who are under 65 years of age documentation of trial and failure, contraindication or intolerance to one formulary stimulant (e.g. methylphenidate, dextroamphetamine/amphetamine). For Obstructive Sleep Apnea: Established diagnosis of Sleep Apnea from a sleep specialist. For Shift Work Sleep Disorder all of the following criteria must be met: a. Diagnosis of shift-work sleep disorder in accordance with criteria stipulated in the International Classification of Sleep Disorders: i. The patient has a primary complaint of insomnia or excessive sleepiness, AND ii. The primary complaint is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase, AND iii. No medical or mental disorder accounts for the symptoms. Ongoing approval will require documentation that Provigil has been effective.
MEDICATION(S)
BUDESONIDE 1 MG/2 ML INH SUSP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

PRESCRIBER RESTRICTION
NA

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

OTHER CRITERIA
Trial and failure of one of the formulary corticosteroid inhalers.
PULMONARY ARTERIAL HYPERTENSION

MEDICATION(S)
BOSENTAN, LETAIRIS, OPSUMIT, ORENITRAM ER, UPTRAVI 1,000 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG 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 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
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 approval and re-authorization: 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 add'l 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.
MEDICATION(S)
RITUXAN

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.
SABRIL

**MEDICATION(S)**
VIGABATRIN 500 MG TABLET, VIGADRONE

**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**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
For refractory complex partial seizures: Documentation of trial and failure, contraindication, or intolerance to at least two (2) alternative formulary generic antiepileptic medications.
**MEDICATION(S)**
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**
Initial authorization and reauthorization will be approved for 30 days.
OTHER CRITERIA
For autosomal dominant polycystic kidney disease (ADPKD), 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 euvoletic hyponatremia, 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 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 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
Authorization will be approved until no longer eligible with the plan.

OTHER CRITERIA
Documentation demonstrating that the patient has been maintained on simvastatin 80 mg for 12 months or more without evidence of muscle toxicity.
MEDICATION(S)
SOMATULINE DEPOT

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
Acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy.
MEDICATION(S)
SOMAVER

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 endocrinologist.

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.
STELARA

MEDICATION(S)
STELARA

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
Psoriatic arthritis: must be prescribed by, or in consultation with, a dermatologist or rheumatologist.

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

OTHER CRITERIA
For psoriatic arthritis: Documented inadequate response to at least one DMARD after at least 3 months of therapy: methotrexate, leflunomide, sulfasalazine or hydroxychloroquine. For Crohn's disease: documented inadequate response to at least 3 months trial of TNF antagonist or immunomodulators or corticosteroids
MEDICATION(S)
SYLVANT 100 MG VIAL

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. For all indications, documentation of response must be submitted in order for continued authorization.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
**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**
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%.
SYMPAZAN

**MEDICATION(S)**
SYMPAZAN

**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**
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)**
TRIENTINE HCL

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

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Cystinuria AND 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 or hepatologist.

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

**OTHER CRITERIA**
Documentation of severe or intolerable adverse effects to penicillamine (Depen).
**MEDICATION(S)**
ALYQ, SILDENAFIL 10 MG/12.5 ML VIAL, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET

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

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Patients using organic nitrates, either regularly and/or intermittently.

**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**
Prescribed by or in consultation with a cardiologist or pulmonologist.

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

**OTHER CRITERIA**
The following criteria must be documented: Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: 1. Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg at rest or greater than 30 mmHg with exercise. AND 2. Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. When sildenafil or tadalafil are used in conjunction with other treatment for PAH, specifically epoprostenol (Flolan), treprostinil (Remodulin) or bosentan (Tracleer), the combination will be reviewed on a case-by-case basis and must be prescribed by a physician specializing in the management of pulmonary arterial hypertension. For continued approval of combination therapy with PAH medications, successful improvement within three months of therapy is needed.
MEDICATION(S)
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 99mTcTechnetium-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)
TAKHZYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Combination prophylaxis therapy with Cinryze or Haegarda

REQUIRED MEDICAL INFORMATION
Complement Component C4 and C1-Esterase inhibitor OR C1-Esterase Functional. 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 an 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) Documentation of one of the following clinical criteria: a) Self-limiting, recurrent noninflammatory subcutaneous angioedema without urticaria or b) Self-remitting recurrent abdominal pain without clear organic etiology or c) Recurrent laryngeal edema: AND 2) Trial and failure, intolerance or contraindication to androgen therapy, such as danazol, stanozolol or oxandrolone unless not indicated (e.g., pregnancy, lactation, pre-pubescent children, hepatitis) AND 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 is less than 50 percent the lower limit of normal, AND ii) One of the following: (1) C1-inhibitor (C1-INH) protein is less than the laboratory defined lower limit of normal, or (2) C1-INH function is less than the laboratory defined 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. Reauthorization: Documentation of response to therapy
MEDICATION(S)
THIOLA

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 and 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).
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 Chrohn's disease, the use of Tysabri in combination with immunosuppressants or inhibitors of TNF-a 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), or 5) glatiramer acetate (Copaxone) 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 (PML). 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.
MEDICATION(S)
VASCEPA 1 GM CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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. For all indications, documentation of response must be submitted in order for continued authorization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
1. Trial (defined as 2 months of therapy), failure, or contraindication one formulary agent to treat very high triglycerides such as fenofibrate. 2. A triglyceride level within the past 6 months that is greater than 500 mg/ml.
VIDAZA

MEDICATION(S)
AZACITIDINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NA

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
NA

PRESCRIBER RESTRICTION
NA

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

OTHER CRITERIA
NA
**MEDICATION(S)**
AUSTEDO, INGREZZA

**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 approved for one 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.
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
NA

PRESCRIBER RESTRICTION
NA

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, AND 2. Documentation of trial and failure, intolerance, or contraindication to one conventional therapy prerequisite for the requested indication (see notes below), AND 3. Documentation of trial and failure, intolerance, or contraindication to one of the following biologic immunomodulators according to patients diagnosis: a. For rheumatoid arthritis: Enbrel or Humira, b. For psoriatic arthritis: Enbrel, Humira, Otezla or Cosentyx, c. For ulcerative colitis: Humira, AND 4. 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: No prerequisites are required for diagnosis ulcerative colitis. Use of ONE conventional agent prerequisite is required for diagnoses of psoriatic arthritis or rheumatoid arthritis. Formulary conventional agents for rheumatoid arthritis or psoriatic arthritis include methotrexate, hydroxychloroquine, sulfasalazine, minocycline, or leflunomide.
MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active suicidality and/or untreated or inadequately treated depression. Hepatic Impairment. Use in combination with monoamine oxidase inhibitors or reserpine.

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 prior auth will be approved for 3 months. Reauth may be approved for 1 yr.

OTHER CRITERIA
All of the following must be met: Diagnosis of Huntington Disease as defined by: a. DNA testing showing CAG expansion of more than 36 AND b. Family History (if known) AND c. Classic Presentation (choreiform movements, psychiatric problems, and dementia). After initial 3 month authorization and at least annually, documentation must be provided showing benefit of therapy with improved function through reduction of choreiform movements.
MEDICATION(S)
XERMELO

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 or hematologist.

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

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)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For prevention of skeletal-related events in patients with bone metastases from solid tumors: documentation confirming bone metastasis. 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
For prevention of skeletal-related events in patients with bone metastases from solid tumors: Documented trial and failure of, intolerance to, or contraindication to zoledronic acid or pamidronate therapy.
**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) 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
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be 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. Reauthorization requires documentation that treatment has been effective.