Prior Authorization Requirements

Effective Date 01/01/2027

Abatacept

Products Affected

- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Orencia will not be approved for use in combination with other potent immunosuppressants, such as biologic DMARDs or Janus Kinase inhibitors.
Required Medical Information	Diagnosis, current and previous therapies used for the treatment of the stated diagnosis. For acute graft versus host disease, documentation patient is undergoing hematopoietic stem cell transplantation .
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	Covered for prophylaxis of acute graft versus host disease (in combination with a calcineurin inhibitor and methotrexate) in adults and pediatric patients at least 2 years of age undergoing hematopoietic stem cell transplantation from a matched or 1 allele-mismatched unrelated donor. Covered for the treatment of psoriatic arthritis. Covered for the treatment of active moderate to severe rheumatoid arthritis or juvenile idiopathic arthritis in patients with polyarticular disease who have intolerance or failure to respond to one of the following approved disease-modifying antirheumatic drug (DMARD) agents, such as methotrexate, azathioprine, sulfasalazine, or hydroxychloroquine, either alone or in combination for a 3-month period. Orencia will not be approved for use in combination with other potent immunosuppressants, such as biologic DMARDS or Janus Kinase inhibitors. Request will also be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Abemaciclib - CDK 4/6

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. For shared indications, coverage of Verzenio/abemaciclib requires intolerance or contraindication to Ibrance/palbociclib OR Kisqali/ribociclib. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Abiraterone - Oral Oncology

Products Affected

- *abiraterone oral tablet 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Abiraterone - Yonsa

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis as confirmed by elevated prostate-specific antigen (PSA) test and any one of the following: biopsy, imaging study or lab diagnostic test such as 4Kscore Test or Prostate Health Index (PHI). Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or urologist.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of metastatic castration-resistant prostate cancer. In addition, documentation of contraindication to both abiraterone and Xtandi (enzalutamide) must be provided. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Abiraterone/Niraparib - Oral Oncology

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Acalabrutinib - BTKi

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis and previous therapies used for requested condition, if any
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Acoramidis

Products Affected

- ATTRUBY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent lab/diagnostic tests, including tests confirming presence of TTR amyloid in cardiac tissue such as 99m Technetium-labeled pyrophosphate cardiac imaging test results (nuclear scintigraphy) positive for TTR amyloid or genetic testing/next-generation sequencing confirming a variant TTR genotype and/or TTR precursor protein.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a specialist experienced in the diagnosis of Transthyretin-mediated Amyloidosis (ATTR-CM), such as a cardiologist.
Coverage Duration	One year.
Other Criteria	Covered for patients with a diagnosis of cardiomyopathy of wild-type (wtATTR-CM) or Hereditary Transthyretin-mediated Amyloidosis (hATTR-CM). Must present clinical evidence of NYHA class I-III heart failure. Evidence of cardiac involvement seen on echocardiography and/or cardiac magnetic imaging, such as thickened left ventricle wall or septum, must be provided. Presence of TTR amyloid in cardiac tissue must be confirmed via 99m Technetium-labeled pyrophosphate cardiac imaging test results (nuclear scintigraphy) positive for TTR amyloid or via genetic testing/next-generation sequencing confirming a variant TTR genotype and/or TTR precursor protein correlated with amyloid deposits identified on cardiac biopsy. Upon recertification, there must be documentation that the patient continues to obtain clinical benefit from the therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adagrasib - Oral Oncology

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adalimumab - Humira Biosims

Products Affected

- HADLIMA
- HADLIMA (CITRATE-FREE)
- HADLIMA (CITRATE-FREE) PUSHTOUCH
- HADLIMA PUSHTOUCH
- SIMLANDI (CITRATE-FREE) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML
- SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.

PA Criteria	Criteria Details
Other Criteria	Covered for ANKYLOSING SPONDYLITIS (AS) for pts w/ refractory disease defined by failure of at least one NSAID at maximally tolerated dose for at least 1 month. Covered for moderate to severe active CROHN'S DISEASE. Covered for moderate to severe HIDRADENITIS SUPPURATIVA. Covered for moderate to severely active JUVENILE IDIOPATHIC ARTHRITIS (JIA) in pts who have failed to respond to or are intolerant of ONE of the first line agents from the following categories, either alone or in combination for a 3-month period - DMARDs (such as MTX), NSAIDS, analgesics, or corticosteroids. Covered for moderate to severe chronic PLAQUE PSORIASIS that involves at least 3% of their body surface area (BSA). Covered for the diagnosis of moderate to severe chronic PLAQUE PSORIASIS in patients with less than 3% BSA if the affected area involves the hands, feet, face, genital region, or scalp. Patient also must meet one of the following criteria (requirement bypassed if patient has tried UVB and coal tar or PUVA and topical corticosteroids - a non-Part D service): 1) had a 3-month trial of acitretin, methotrexate (MTX), or cyclosporine therapy resulting in intolerance or clinical failure OR 2) have tried and failed at least TWO of the following for 3 months: treatment with medium and/or high potency topical corticosteroids or anthralin, calcipotriene, or tazarotene. Covered for PSORIATIC ARTHRITIS (PsA). Covered for active moderate to severe RHEUMATOID ARTHRITIS (RA) in pts who have failed to respond to or are intolerant of ONE approved disease-modifying antirheumatic drug (DMARD) agent, such as MTX, azathioprine, sulfasalazine, or hydroxychloroquine, either alone or in combination for a 3-month period. Covered for moderately to severely active ULCERATIVE COLITIS (UC). Covered for non-infectious intermediate, posterior uveitis and panuveitis in pts with an ineffective response, contraindication, or intolerance to TWO of the following regimens: 1) topical or injected ophthalmologic steroid, 2) oral systemic steroid, 3) immunosuppressive agent, such as azathioprine, mycophenolate, or MTX. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Adapalene - Topical Retinoids

Products Affected

- *adapalene topical cream*
- *adapalene topical gel 0.3 %*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for cosmetic purposes
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Approved for the diagnosis of acne vulgaris. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Afatinib - Oral Oncology

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alectinib - Oral Oncology

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alpelisib - Oral Oncology

Products Affected

- PIQRAY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alpelisib - Vijoice

Products Affected

- VIJOICE ORAL GRANULES IN PACKET
- VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Covered for the treatment of adult and pediatric patients 2 years of age and older with severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) who require systemic therapy. There must be submitted documentation of a mutation in the PIK3CA gene and the patient must have at least one target lesion identified on imaging at baseline. Recertification will require documentation from provider of objective or subjective evidence that patient has derived clinical benefit from the use of Vijoice. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alpha 1-Antitrypsin

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic test results (such as AAT serum levels, genotype testing, and pulmonary function testing, or other tests performed to confirm the diagnosis, and documentation of previous therapies
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist
Coverage Duration	One year, only as weekly infusions.
Other Criteria	Coverage will not be provided for alpha antitrypsin deficits other than the ones defined here: patients with alpha 1 antitrypsin (AAT) levels below 11 micromol/L (80mg/dL or approximately 57mg/dL by nephelometry) who are PiZZ, PiSZ, PiZ(null), Pi(null)(null), Pi(malton,malton), Pi(Siiyama,Siiyama) or have dysfunctional AAT protein (such as PiF or Pi Pittsburg genotypes) AND have evidence of emphysema as FEV1 less than 80% of predicted value. Patients must also demonstrate 1 or more of the following: signs of significant lung disease such as chronic productive cough or unusual frequency of lower respiratory infection, airflow obstruction, accelerated decline of FEV1 or chest radiograph or CT scan evidence of emphysema, especially in the absence of a recognized risk factor (smoking, occupational dust exposure, etc.). In addition, patients with emphysema due to AAT deficiency must be maintained on regimens similar to those patients with emphysema not associated with AAT deficiency, including: maximally tolerated doses of beta-adrenergic bronchodilators, anticholinergics and antibiotics, when appropriate and no contraindications exist. Request will also be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Amantadine - Parkinson's

Products Affected

- GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	For the treatment of off episodes in Parkinson's disease, Gocovri is covered for patients with documentation of a contraindication, inadequate response, or intolerance to TWO generic anti-Parkinson's disease drugs with different mechanisms of action. Examples include COMT inhibitors (entacapone and tolcapone), dopamine agonists (pramipexole, ropinirole, amantadine, and bromocriptine), MAO B-inhibitors (rasagiline and selegiline), and anticholinergics (benztropine). For the treatment of dyskinesia associated with Parkinson's disease, Gocovri is covered in combination with levodopa/carbidopa for patients with documentation of a contraindication, inadequate response, or intolerance to immediate-release amantadine. Recertification for the treatment of off episodes will require objective and/or subjective evidence from prescriber of a decrease in frequency and/or severity of wearing-off symptoms. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ambrisentan - Pulmonary Arterial Hypertension (PAH)

Products Affected

- *ambrisentan oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Amifampridine

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent lab/diagnostic test results
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or neuromuscular specialist
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of Lambert-Eaton Myasthenic Syndrome that has been confirmed by electromyography or calcium channel antibody testing. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Amikacin

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for the treatment of patients with non-refractory mycobacterium avium complex (MAC) disease or when being used as a single agent.
Required Medical Information	Diagnosis, submission of positive sputum culture result obtained after a minimum 6-month treatment with a multi-drug regimen (such as clarithromycin/azithromycin, rifampin, and ethambutol), attestation patient will be using Arikayce in combination with other medications as part of a multi-drug regimen.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an infectious disease specialist or pulmonologist.
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Recertification will require documentation of a negative sputum culture while using Arikayce taken within 30 days prior to the recertification request. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Amphetamine

Products Affected

- *amphetamine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for weight loss, even if non-cosmetic (such as morbid obesity).
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anakinra

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent lab/diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of moderate to severe RHEUMATOID ARTHRITIS for patients with documented failure to TWO of the following alternatives: Hadlima, Orencia, Rinvoq, Simlandi, Xeljanz/XR. Covered for the diagnosis of neonatal-onset multisystem inflammatory disease (NOMID). Covered for a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) in patients who have a confirmed mutation in the IL1RN gene. Recertification will require provider attestation that the patient has maintained a response to treatment. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Apalutamide

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis as confirmed by elevated prostate-specific antigen (PSA) test and any one of the following: biopsy, imaging study or lab diagnostic test such as 4Kscore Test or Prostate Health Index (PHI). Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of nonmetastatic, castration-resistant prostate cancer in patients with documentation of contraindication or had serious side effects to Nubeqa and Xtandi. Covered for a diagnosis of metastatic castration-sensitive prostate cancer in patients with documentation of contraindication or serious side effects to abiraterone and either Xtandi or Nubeqa. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Apomorphine - Parkinson's

Products Affected

- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of off episodes in Parkinson's disease patients established on levodopa/carbidopa therapy. Patient must have documented attempts at levodopa/carbidopa dose and/or frequency adjustment, up to a maximum tolerated dose is achieved or intolerance is experienced, to mitigate "wearing-off" and/or unpredictable "on"/"off" episodes. Recertification will require objective and/or subjective evidence from prescriber of a decrease in frequency and/or severity of "wearing-off" and/or unpredictable "on"/"off" episodes. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Apremilast

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)
- OTEZLA XR
- OTEZLA XR INITIATION

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, BSA if for psoriasis, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For Psoriatic Arthritis and Plaque Psoriasis, prescriber must be a Dermatologist or Rheumatologist
Coverage Duration	One year.
Other Criteria	Otezla is covered for the diagnosis of oral ulcers associated with BECHET'S DISEASE. Covered as treatment for adults with PLAQUE PSORIASIS who are candidates for phototherapy or systemic therapy and treatment of pediatric patients at least 6 years of age and at least 20 kg (immediate release) or at least 50 kg (extended release) with moderate to severe plaque psoriasis (BSA of at least 3%) who are candidates for phototherapy or systemic therapy. BSA of at least 3% is not required if the affected area involves the hands, feet, scalp, facial or genital regions. Patients also must meet ONE of the following criteria: 1) had a 3-month trial of acitretin, methotrexate, or cyclosporine therapy resulting in intolerance or clinical failure or 2) have tried UVB/coal tar or PUVA/topical corticosteroids for at least 3 months or 3) have tried and failed at least two of the following for 3 months: treatment with medium and/or high potency topical corticosteroids or anthralin, calcipotriene, or tazarotene. Otezla is covered for patients with a diagnosis of PSORIATIC ARTHRITIS. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Aripiprazole - Behavioral Health

Products Affected

- OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Coverage of Opipza oral film requires documentation that all other oral dosage forms of aripiprazole (oral solution, oral tablets, oral disintegrating tablets) cannot instead be used. Additionally, for the shared indications MAJOR DEPRESSIVE DISORDER (MDD) and SCHIZOPHRENIA, documentation of a contraindication, inadequate response, or intolerance to Vraylar is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Armodafinil - Sleep Disorders

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, sleep study results, and documentation of outcome with previous therapies attempted for the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or sleep specialist for a diagnosis of cataplexy or excessive daytime sleepiness associated with narcolepsy. Must be prescribed by a neurologist, sleep specialist, or pulmonologist for a diagnosis of Excessive Daytime Sleepiness associated with Obstructive Sleep Apnea.
Coverage Duration	One year
Other Criteria	Armodafinil is are covered for a diagnosis of excessive daytime sleepiness associated with narcolepsy, excessive daytime sleepiness associated with obstructive sleep apnea (OSA), and shift-work disorder. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Asciminib - Oral Oncology

Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Asenapine - Behavioral Health

Products Affected

- *asenapine maleate*
- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For BIPOLAR DISORDER, coverage of asenapine requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). For SCHIZOPHRENIA, coverage of asenapine or Secuado requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Avacopan

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, current and previous therapies used for the treatment of the stated diagnosis. Must either have a positive test for antibodies to proteinase 3 (PR3) or myeloperoxidase (MPO) or have histological evidence of GPA or MPA via biopsy.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a rheumatologist, nephrologist, pulmonologist, or immunologist.
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Covered as adjunctive treatment for patients with a diagnosis of active and severe anti-neutrophil cytoplasmic autoantibody (ANCA) associated vasculitis (granulomatosis with polyangiitis [GPA] or microscopic polyangiitis [MPA]). Tavneos must be used as adjunctive treatment in combination with standard of care therapy (such as cyclophosphamide, azathioprine, mycophenolate mofetil, rituximab, glucocorticoids). Recertification will require documentation of disease remission, defined as the absence of clinical signs or symptoms attributed to GPA or MPA while on Tavneos. Recertification requires that Tavneos continue to be used in combination with standard of care therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Avapritinib - Oral Oncology

Products Affected

- AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Avatrombopag

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a hematologist, gastroenterologist, hepatologist, or surgeon.
Coverage Duration	One month for chronic liver disease-associated thrombocytopenia. Two years for chronic ITP.
Other Criteria	Covered for a diagnosis of thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure. For this diagnosis, platelet count must be less than 50,000 platelets per microliter. Covered for a diagnosis of chronic immune thrombocytopenia purpura (ITP) in patients who have experienced an insufficient response to previous treatment with either a corticosteroid or immunoglobulin therapy (IVIG). Insufficient response is defined as a platelet count of less than 30,000/microliter or greater than 30,000/microliter but with bleeding symptoms. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Avutometinib/Defactinib - Oral Oncology

Products Affected

- AVMAPKI-FAKZYNJA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Axitinib - Oral Oncology

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Azacitidine - Oral Oncology

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Belimumab

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for patients who are currently receiving treatment with any B-cell-targeted therapy or biologic.
Required Medical Information	Diagnosis. Attestation that patient is currently using standard therapy to treat diagnosis and that such standard therapy will be continued after Benlysta is started. Standard therapy is defined consistent with current recommended clinical practice as hydroxychloroquine (unless contraindicated), and possibly immunosuppressive agents such as azathioprine, mycophenolate mofetil, methotrexate, tacrolimus, cyclosporine, or cyclophosphamide added with or without corticosteroids to control inflammation and prevent organ damage.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be followed by a Rheumatologist or Nephrologist
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Belumosudil

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a healthcare provider experienced in the management of transplant rejection and/or graft-versus-host disease.
Coverage Duration	Initial approval - 6 months. Recertifications - 2 years.
Other Criteria	Covered for patients with a diagnosis of chronic graft-versus-host disease (cGVHD) who have had inadequate response or intolerance with at least 2 prior lines of therapy, one of which must be Imbruvica/ibrutinib. If ibrutinib is contraindicated, then a trial of at least 2 therapies is required prior to Rezurock for cGVHD. Upon recert, documentation of positive response to therapy must be provided. Positive response is defined as resolution of all manifestations in each organ or site, or improvement in at least one organ or site without progression in any other organ or site. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Belzutifan

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. For von Hippel-Lindau (VHL) disease only, diagnostic test results showing germline VHL alteration.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist, urologist, nephrologist or provider who specializes in von Hippel-Lindau (VHL) disease.
Coverage Duration	6 months.
Other Criteria	Covered for treatment of advanced renal cell carcinoma in adults following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI). Covered for patients with a diagnosis of von-Hippel-Lindau disease who have a confirmed germline VHL alteration and require therapy for one of the following: renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastoma, or pancreatic neuroendocrine tumor (PNET). Covered for treatment of patients with locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma (PPGL). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Betamethasone/Calcipotriene - Topical Psoriasis Combos

Products Affected

- *calcipotriene-betamethasone*
- ENSTILAR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for a diagnosis of psoriasis. In addition, there must be lack of clinical response or intolerance to one generic topical steroid AND either a generic topical vitamin D analog or a generic topical retinoid. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Bexarotene - Bexarotene Gel

Products Affected

- *bexarotene topical*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or dermatologist.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of refractory or persistent cutaneous t-cell lymphoma (CTCL) (stage 1a or 1b) after failure with or inability to tolerate at least one other therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Binimetinib - BRAF/MEK

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bosentan - Pulmonary Arterial Hypertension (PAH)

Products Affected

- *bosentan oral tablet 125 mg, 62.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Bosutinib - Oral Oncology

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG
- *bosutinib oral tablet 100 mg, 400 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Brensocatib

Products Affected

- BRINSUPRI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis of non-cystic fibrosis bronchiectasis (NCFB), confirmed (or documented) by high-resolution chest CT scan.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a pulmonologist or infectious disease specialist experienced in treating bronchiectasis.
Coverage Duration	One year.
Other Criteria	There must be a documented history of at least 2 pulmonary exacerbations in the past 12 months requiring systemic antibiotics OR at least 1 exacerbation requiring hospitalization/IV antibiotics.Recertification requires documentation of or provider attestation of clinical benefit (i.e., a reduction in pulmonary exacerbations, improved symptoms). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Brexpiprazole - Behavioral Health

Products Affected

- REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for AGITATION ASSOCIATED WITH DEMENTIA DUE TO ALZHEIMER DISEASE. For MAJOR DEPRESSIVE DISORDER (MDD), coverage of Rexulti requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment indicated for MDD (such as SSRIs, SNRIs, bupropion, mirtazapine). For SCHIZOPHRENIA, coverage of Rexulti requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Brigatinib - Oral Oncology

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Budesonide - Budesonide Foam

Products Affected

- *budesonide rectal*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. As topical budesonide does not have proven efficacy to maintain remission, chronic therapy with budesonide foam will not be authorized.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a gastroenterologist
Coverage Duration	Initial approval - 6 weeks. Subsequent courses will be authorized at 6-week intervals.
Other Criteria	For the treatment of ulcerative colitis, the patient must have had a contraindication, inadequate response, or severe intolerance to/serious side effects from topical mesalamine (enemas or suppositories), or hydrocortisone enemas. Approval for future treatment courses will require documentation of remission from the initial course of therapy. In addition, documentation that remission failed on a course of an appropriate immunomodulator or biologic will be required. If the criteria are met, subsequent treatment courses will be approved in 6-week intervals. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Budesonide - Tarpeyo

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a nephrologist or provider specializing in IgA nephropathy
Coverage Duration	10 months.
Other Criteria	Covered for patients with a diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed on biopsy. Patient must have proteinuria (defined as greater than or equal to 0.5 g/day or urine protein creatinine ratio (UPCR) greater than or equal to 0.8 g/g). Patient must also be on an ACE Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) at the maximally tolerated dose, unless the patient is unable to tolerate or drug class is contraindicated. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Bupropion/Dextromethorphan - Behavioral Health

Products Affected

- AUVELITY ORAL TABLET, IR AND ER, BIPHASIC
- AUVELITY ORAL TABLET,IR ER BIPHASIC,DOSEPACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For MAJOR DEPRESSIVE DISORDER (MDD), coverage of Auvelity requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment indicated for MDD (such as SSRIs, SNRIs, bupropion, mirtazapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

C1 Esterase Inhibitor - Prophylactic Hereditary Angioedema (HAE)

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for acute hereditary angioedema attacks.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by allergist, immunologist, hematologist, or dermatologist
Coverage Duration	One year
Other Criteria	Covered for a confirmed diagnosis of HAE type 1, type II, or type III. Prophylactic therapy will be covered for individuals whose provider has determined that prophylactic therapy is medically necessary, after consideration of such factors as disease burden, activity of disease, frequency of attacks, patient preference, quality of life, and availability of healthcare resources. Objective and/or subjective documentation of these considerations must be provided. Recertification requires objective and/or subjective evidence of clinical benefit from use of the drug. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cabozantinib - Oral Oncology

Products Affected

- CABOMETYX
- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cannabidiol

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Capivasertib - Oral Oncology

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Caplacizumab

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, attestation patient will continue to receive plasma exchange and immunosuppressive therapy (such as systemic corticosteroids or rituximab) while using Cablivi.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a hematologist
Coverage Duration	Initial approval - 3 months. Recertification - 1 month.
Other Criteria	Covered for patients with a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) when being used in combination with plasma exchange and immunosuppressive therapy (such as systemic corticosteroids or rituximab). Should documentation of underlying disease persist (such as suppressed ADAMTS13 activity levels) after the initial treatment period (up to 30 days beyond the last plasma exchange), recertification will be approved for an additional 1 month of therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Capmatinib - Oral Oncology

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Carglumic Acid

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for acute or chronic hyperammonemia due to the deficiency of the hepatic enzyme n-acetylglutamate synthase (NAGS). Covered as adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cariprazine - Behavioral Health

Products Affected

- VRAYLAR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For BIPOLAR DISORDER, coverage of Vraylar requires documentation of a contraindication, inadequate response, or intolerance to two generic first-line treatments (such as lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). For MAJOR DEPRESSIVE DISORDER (MDD), Vraylar requires documentation of a contraindication, inadequate response, or intolerance to TWO generic first-line treatments indicated for MDD (such as SSRIs, SNRIs, bupropion, mirtazapine). For SCHIZOPHRENIA, coverage of Vraylar requires documentation of a contraindication, inadequate response, or intolerance to two generic first-line treatments (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cedazuridine/Decitabine - Oral Oncology

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ceritinib - Oral Oncology

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cholic Acid

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis and pertinent lab/diagnostic test results (such as gas chromatography-mass spectrometry urine analysis, liver function tests and other tests performed to confirm the diagnosis).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist, gastroenterologist, geneticist, hepatologist, or metabolic specialist.
Coverage Duration	Initial approval - 3 months. Recertifications - 1 year.
Other Criteria	For its FDA approved indications, there must be a diagnosis made by gas chromatography-mass spectrometry analysis of the urine with a positive identification of elevated bile acids. In addition, liver function tests must identify elevated serum aminotransferases with normal serum gamma glutamyltransferase. The initial approval will be for three months. After the initial three-month authorization, approval will be granted in one-year increments with documentation of improved liver function via aminotransferase lowering. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Chorionic Gonadotropin

Products Affected

- *chorionic gonadotropin, human intramuscular*
- PREGNYL

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used to promote fertility.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Clomiphene

Products Affected

- *clomiphene citrate*
- MILOPHENE

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used to promote fertility.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cobimetinib - BRAF/MEK

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Corticotropin - Acthar

Products Affected

- ACTHAR
- ACTHAR SELFJECT
- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	For all FDA approved indications in adults, documentation of contraindication, inadequate response, or intolerance to/serious side effects (such as steroid-induced mania or sepsis) from oral or injectable corticosteroids is required. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Crizotinib - Oral Oncology

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Crofelemer

Products Affected

- MYTESI

PA Criteria	Criteria Details
Exclusion Criteria	Drug therapy will not be authorized for individuals who have a history of Ulcerative colitis, Crohn's disease, Celiac sprue, chronic pancreatitis, malabsorption, or any other GI disease associated with diarrhea.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for the symptomatic relief of noninfectious diarrhea in individuals with HIV/AIDS on anti-retroviral therapy. In addition, documentation of clinical failure to either loperamide or diphenoxylate is required. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cyclobenzaprine - High-Risk Medications

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for treatment of chronic conditions (conditions that persist for greater than 3 weeks).
Required Medical Information	Documentation that the safer alternatives baclofen and tizanidine have been tried.
Age Restrictions	Prior authorization applies to patients aged 65 and older. Criteria does not apply to patients under 65 years of age.
Prescriber Restrictions	None
Coverage Duration	Approval 30 days. To allow for treatment of a DIFFERENT acute condition, max 2 approvals/365 days.
Other Criteria	Covered for short-term (2 to 3 weeks) relief of muscle spasm associated with acute, painful musculoskeletal conditions. Must have documented trial and inadequate response or severe intolerance to baclofen OR tizanidine. Recertification will not be authorized for the treatment of the same condition for which cyclobenzaprine was previously approved (as this suggests a chronic condition). Note: Per the American Geriatric Society (AGS), certain skeletal muscle relaxers, like cyclobenzaprine, can leave patients feeling groggy and confused, increase risk of falls, and cause constipation, dry mouth, and problems urinating. Plus, there is little evidence that they work well. Due to the high risk and low clinical value of this medication in patients 65 and older, requests for non-FDA approved indications, including chronic use (treatment of a muscle spasm associated with a painful musculoskeletal condition lasting more than 3 weeks) will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cyclosporine

Products Affected

- VERKAZIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an ophthalmologist
Coverage Duration	One year.
Other Criteria	Covered for patients with a diagnosis of vernal keratoconjunctivitis (VKC). The patient must have had serious side effects or drug failure to an ophthalmic antihistamine with mast cell stabilizer properties (such as olopatadine, azelastine, or epinastine) OR an antihistamine eye drop in combination with a mast cell stabilizer (such as cromolyn or Alocril). In addition, the patient must have had persistent symptoms despite treatment with an ophthalmic steroid or an inability to titrate off ophthalmic steroids. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cysteamine

Products Affected

- PROCYSBI

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to penicillamine and as limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a nephrologist, genetic or metabolic specialist
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of nephropathic cystinosis in patients who have demonstrated therapeutic failure, contraindication, or intolerance to immediate release cysteamine/Cystagon. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Dabrafenib - BRAF/MEK

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dacomitinib - Oral Oncology

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Darolutamide - Oral Oncology

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dasatinib - Oral Oncology

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Deflazacort

Products Affected

- *deflazacort oral suspension*
- *deflazacort oral tablet 18 mg, 30 mg, 36 mg, 6 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, current and previous therapies for stated diagnosis, results of Duchenne Muscular Dystrophy (DMD) gene mutation study
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year.
Other Criteria	Covered for all FDA approved indications with required documentation of significant side effects resulting from a minimum 3-month trial of oral prednisone. Examples of significant prednisone side effects include cushingoid appearance, central (truncal) obesity, undesirable weight gain, inability to manage diabetes or hypertension, steroid-induced mania, or sepsis. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Denosumab - Xgeva

Products Affected

- BILPREVDA
- XTRENBO

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved for use in combination with oral or injectable bisphosphonates.
Required Medical Information	Documentation of diagnosis. For a diagnosis of bone metastasis from solid tumor, provide radiographic evidence (X-ray, CT, or MRI) of a least one bone metastasis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist.
Coverage Duration	One year
Other Criteria	Covered for the prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors for which there is radiographic evidence of at least one bone metastasis. Approved for treatment of giant cell tumor of the bone (in adults and skeletally mature adolescents) that is unresectable or where surgical resection is likely to result in severe morbidity. Approved for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Deutetrabenazine

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG

PA Criteria	Criteria Details
Exclusion Criteria	Will not be covered in combination with tetrabenazine (Xenazine).
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or a psychiatrist
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dextromethorphan/Quinidine

Products Affected

- *dextromethorphan-quinidine*
- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests will also be evaluated for off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dichlorphenamide

Products Affected

- *dichlorphenamide*
- ORMALVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or geneticist.
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Diclofenac - Actinic Keratosis

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a Dermatologist or Oncologist
Coverage Duration	One year.
Other Criteria	For the treatment of actinic keratoses, patients must have had a contraindication, inadequate response, or severe intolerance to/serious side effects from generic imiquimod 5% cream and either generic fluorouracil 5% cream or generic fluorouracil solution. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Dihydroergotamine

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Excluded for prevention of migraines or cluster headaches.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a headache or pain specialist or neurologist
Coverage Duration	One year.
Other Criteria	Covered for the acute treatment of migraine headache in patients with documented trial and failure or severe intolerance to two different generic triptans (any dosage form) used in combination with a non-opioid analgesic (such as aspirin, NSAID, or acetaminophen). Will not be approved for prophylactic therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Donepezil/Memantine

Products Affected

- *memantine-donepezil*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Memantine-donepezil will be authorized for patients with a diagnosis of moderate to severe Alzheimer disease. There must also be documented stabilization on donepezil for a minimum of three months immediately preceding the request. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Dordaviprone - Oral Oncology

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Doxepin - Doxepin Topical Cream

Products Affected

- *doxepin topical*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Doxepin topical cream will be covered for the treatment of short-term management of moderate pruritus in adults with atopic dermatitis or lichen simplex chronicus. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dronabinol

Products Affected

- *dronabinol oral capsule*
- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. For a diagnosis of nausea and vomiting associated with cancer chemotherapy, also list previous therapies.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Anorexia due to AIDS - 1 year. Chemo-induced nausea/vomiting - 6 months.
Other Criteria	Covered for the treatment of nausea and vomiting associated with cancer chemotherapy with documented lack of response or severe intolerance to one 5HT-3 receptor antagonist. Covered for treatment of anorexia associated with weight loss in patients with AIDS. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Droxidopa

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dulaglutide - GLP-1 Agonists

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for weight management and as limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for the treatment of type 2 diabetes mellitus. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dupilumab

Products Affected

- DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML
- DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Not indicated for other forms of urticaria other than chronic spontaneous urticaria (CSU).
Required Medical Information	Diagnosis. For all submissions of previous therapies used, see Other Criteria. For MODERATE-TO-SEVERE EOSINOPHILIC ASTHMA: (1) either (a) blood eos count at least 150 cells/mcL obtained w/in 6 wks of therapy initiation OR (b) evidence of daily oral steroid dependence and (2) adults with pre-bronchodilator FEV1 less than 80% predicted and (3) previous therapies used. BULLOUS PEMPHIGOID (BP) confirmed by histopathological and direct immunofluorescence (DIF) c/w BP. If no histopath/DIF findings c/w BP, evidence other diagnostics supportive of BP must be provided (e.g., ELIZA, IgG BMZ deposition, indirect immunofluorescence). For COPD: (1) either (a) blood eos count of at least 300 cells/mcL obtained within 6 wks of therapy initiation OR (b) evidence of daily oral steroid dependence and (2) post-bronchodilator FEV1/FVC ratio less than 0.7 and post-bronchodilator FEV1 of 30% to 80% predicted and (3) current therapies. For MOD TO SEVERE ATOPIC DERMATITIS: diagnosis and previous tx used. For CRSwNP: previous tx used. For CHRONIC SPONTANEOUS URTICARIA: (1) at least consecutive 6 wks of symptoms (hives, itching, and/or angioedema) and (2) previous tx used. For EOSINOPHILIC ESOPHAGITIS: (1) dx confirmed by upper endoscopy w/biopsy showing at least 15 eos/high-power field or 60 eos/mm2 and (2) clinical sxs such as difficulty swallowing, food impaction (stuck in the esophagus), acid reflux, N/V, abdominal or chest pain and (3) provider attestation other causes have been ruled out (including, but not limited to GERD, HES, EGPA) and (4) previous tx used. For PRURIGO NODULARIS: (1) pruritus lasting at least 6 wks, (2) signs of repeated scratching, picking, or rubbing (e.g., excoriations and scars), and (3) presence of multiple pruriginous, firm, nodular lesions. For ALLERGIC FUNGAL RHINOSINUSITIS (AFRS): diagnosis supported by clinical documentation (e.g. CT findings, pathology reports, history of surgery, fungal sensitization).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an allergist, gastroenterologist, immunologist, otolaryngologist, pulmonologist or dermatologist
Coverage Duration	Atopic dermatitis: 1 yr. All other diagnoses: initial - 6 months, recert every 1 year thereafter

PA Criteria	Criteria Details
Other Criteria	For COPD: unless there is a documented intolerance or contraindication to one or more components, patient must have at least a 3-month trial of triple therapy consisting of a long-acting muscarinic antagonist, long-acting beta agonist, and inhaled corticosteroid (such as Breztri or Trelegy or by using a combination of products containing these MOA ingredients). For ASTHMA and COPD: Must be used as add-on therapy to existing maintenance therapy. For ATOPIC DERMATITIS: documentation patient is refractory to at least ONE topical therapy. Covered for BULLOUS PEMPHIGOID (BP) with a TWO-week trial of ONE of the following: 1) high-potency topical steroid, 2) oral steroids 3) a tetracycline antibiotic (though not required, doxycycline is preferred based on safety, efficacy, and availability), OR 4) mycophenolate mofetil. For CHRONIC RHINOSINUSITIS WITH NASAL POLYPS: documentation of (1) inadequate response to 8-week trial of an intranasal corticosteroid approved for nasal polyps AND (2) trial of oral steroids in past 6 months OR prior sinus surgery in past 2 years. Recertification will require documentation of continued use of intranasal corticosteroid and clinical benefit from Dupixent use (e.g., reduced polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell). For CHRONIC SPONTANEOUS URTICARIA: patient must have continued symptoms despite an adequate trial (minimum of four weeks) of a second-generation H1-antihistamine at highest tolerated dose up to 2-4 times the standard dose. For EOSINOPHILIC ESOPHAGITIS: documentation of serious side effects or drug failure with oral liquid steroids (e.g., fluticasone or budesonide) plus a proton pump inhibitor at highest tolerated dose up to twice-daily dosing for at least 8 weeks. A positive response may include symptom resolution (an improvement in swallowing, decreased reflux, decreased food impaction) or other subjective or objective evidence from provider that use of Dupixent has improved the patient's condition. For PRURIGO NODULARIS: recertification requires a reduction in symptoms (pruritus) and clearer skin (less firm nodular lesions) from baseline/initial request. For AFRS: prior sinonasal surgery with documented persistent or recurrent disease despite a trial of post-op medical management (either intranasal and/or systemic steroids). Recertification will require documented clinical benefit from Dupixent use (e.g., reduced polyp size, improved nasal congestion or sense of smell, decreased systemic steroid use, or avoidance of repeat sinonasal surgery). RECERTIFICATION for all indications requires some objective or subjective evidence of a positive response to treatment. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Duvelisib - Oral Oncology

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Edaravone

Products Affected

- RADICAVA ORS STARTER KIT SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a provider that specializes in Amyotrophic lateral sclerosis (ALS) and/or neuromuscular disorders
Coverage Duration	One year
Other Criteria	Covered for a diagnosis of Amyotrophic Lateral Sclerosis (ALS) in adult patients. Recertification requires subjective or objective evidence from provider that use of Radicava has improved the patient's condition. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Efgartigimod Alfa/Hyaluronidase

Products Affected

- VYVGART HYTRULO SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	All diagnoses require previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reasons to avoid therapy. For chronic inflammatory demyelinating polyneuropathy (CIDP): documentation of confirmed diagnosis by electrodiagnostic testing (e.g., electromyography (EMG), nerve conduction studies (NCS)), MRI, or nerve biopsy. Documentation of baseline score on an objective scale to assess clinical response (e.g., Rankin, Modified Rankin, Medical Research Council (MRC), Inflammatory Rasch-built Overall Disability Scale (I-RODS), Inflammatory Neuropathy Cause and Treatment (INCAT) disability scale). For Generalized Myasthenia Gravis (gMG): Positive anti-acetylcholine receptor (AChR) antibody test, Myasthenia Gravis Foundation of America (MGFA) clinical classification, MG activities of daily living score.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist or neuromuscular specialist.
Coverage Duration	Initial: 6 months. Recertifications: 1 year.

PA Criteria	Criteria Details
Other Criteria	Covered for patients with a diagnosis of CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) confirmed by electrodiagnostic testing (consistent with EFNS/PNS guidelines) or other diagnostic test such as MRI or nerve biopsy. Must have documentation of an inadequate response, significant intolerance, or contraindication to BOTH of the following within previous 12 months: i. Corticosteroid treatment AND ii. Intravenous or subcutaneous immune globulin (IVIG or SCIG) treatment. Recertification requires documentation of significant clinical improvement in neurologic symptoms or stabilization of disease (measurement of response may include nerve conduction studies, objective clinical measurement tools (e.g. INCAT, Medical Research Council [MRC] sum score, grip strength, etc.) or physical exam showing improvement in neurological strength and sensation. Covered for the treatment of GENERALIZED MYASTHENIA GRAVIS (gMG) in patients with Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV and documentation of a baseline Myasthenia Gravis Activities of Daily Living (MG-ADL) score of at least 5. Must also meet ONE of the following (A or B): A) corticosteroids for at least 3 months of treatment OR non-steroidal immunosuppressive therapy (i.e., azathioprine, mycophenolate mofetil, cyclosporine) for at least 3 months of treatment (note: treatment may be concurrent or subsequent) OR B) ONE immunosuppressive therapy (i.e., corticosteroid, non-steroidal immunosuppressive therapy [i.e., azathioprine, mycophenolate mofetil, cyclosporine]) AND at least one treatment of plasma exchange/plasmapheresis or intravenous immunoglobulin (IVIG). Recertification requires documentation of a positive response to therapy (e.g., improvement in MG-ADL score, MG Manual Muscle Test (MMT), MG Composite) OR subjective/objective evidence from provider that use of drug has improved the patient's condition. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

Eflornithine - Oral Oncology

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Elacestrant - Oral Oncology

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Elagolix

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for patients with severe hepatic impairment (Child-Pugh C) and as limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a gynecologist
Coverage Duration	Dyspareunia/moderate hepatic impairment: 6 mos max. Other: auth 6 mos, recert 18 mos. (24 mos max)
Other Criteria	Covered for a diagnosis of pain associated with endometriosis. In addition, the patient must have a lack of clinical response, intolerance, or contraindication to at least one prescription strength nonsteroidal anti-inflammatory drug (NSAID) used in combination with hormonal therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Elagolix/Estradiol/Norethindrone

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, uterine fibroids must be documented by pelvic ultrasound
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a gynecologist
Coverage Duration	Initial approval - 1 year. Recertification - 1 year.
Other Criteria	Covered for premenopausal female patients with a diagnosis of heavy menstrual bleeding associated with uterine fibroids. Pelvic ultrasound must be provided to confirm diagnosis. Patient must have had serious side effects or drug failure with a contraceptive (such as estrogen-progesterone, progesterone, or hormone-based intrauterine device) and tranexamic acid. Recertification will require objective and/or subjective evidence from provider of improved symptoms. Treatment beyond 24 months (two 12-month courses) will not be approved. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Elapegademase

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	Must not have severe thrombocytopenia (considered to be a platelet count of below 50,000 cells/microliter).
Required Medical Information	Diagnosis confirmed by one of the following (1 or 2): 1) Absent or very low (less than 1 percent of normal) adenosine deaminase (ADA) catalytic activity in plasma, urine, or dried blood spots prior to the initiation of enzyme replacement therapy OR 2) Molecular genetic testing confirming bi-allelic mutations in the ADA gene. Documentation of elevated deoxyadenosine triphosphate (dATP) levels or total deoxyadenosine (dAdo) nucleotides in erythrocytes (red blood cells) compared to a laboratory standard. Current body weight and thrombocyte count.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with an immunologist, hematologist/oncologist, or a physician that specializes in the treatment of ADA-SCID.
Coverage Duration	One year
Other Criteria	Patient must not be a suitable candidate for hematopoietic cell transplantation (HCT) at the time of the request OR have already failed HCT. Recertification requires documentation of a favorable response to treatment such as one or more of the following: a. Improvement in immune status relative to baseline before treatment (total lymphocyte and B, T, and natural killer (NK) lymphocyte counts, quantitative immunoglobulin (Ig) concentration [IgG, IgA, IgM]), b. Improvement in clinical status relative to baseline before treatment (infection rate, incidence and duration of hospitalization, and performance status) c. Normalization of plasma ADA activity, erythrocyte dATP, or total dAdo nucleotide levels compared to a laboratory standard. Requests will be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Elexacaftor/Ivacaftor/Tezacaftor

Products Affected

- TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL
- TRIKAFTA ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will be excluded in patients that lack the required genetic mutation(s) targeted by the medication.
Required Medical Information	Diagnosis, genetic test results showing at least one copy of the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive based on clinical and/or in vitro data. Responsive mutations are those outlined in FDA labeling.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Elranatamab - Injectable Oncology

Products Affected

- ELREXFIO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Eltrombopag

Products Affected

- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*
- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For ITP or aplastic anemia, must be prescribed by a Hematologist. For thrombocytopenia with Hep C, must be prescribed by GI, Hepatologist, Infectious Disease, or HCV/HIV specialist.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of chronic or persistent immune thrombocytopenia purpura (ITP) in patients who have experienced an insufficient response to previous treatment with either ONE of the following: corticosteroids or immunoglobulins (IVIG). Insufficient response is defined as a platelet count of less than 30,000/microliter OR at least 30,000/microliter but with bleeding symptoms. Covered for a diagnosis of thrombocytopenia in patients with chronic Hepatitis C to allow initiation and maintenance of interferon-based therapy. Covered for first-line treatment of severe aplastic anemia, in combination with standard immunosuppressive therapy. Covered for severe refractory aplastic anemia in patients who have experienced an insufficient response to immunosuppressive therapy (such as antithymocyte globulin (ATG) alone or in combination with cyclosporine and/or a corticosteroid). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

Enasidenib - Oral Oncology

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Encorafenib - BRAF/MEK

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ensartinib - Oral Oncology

Products Affected

- ENSACOVE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Entrectinib - Oral Oncology

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Enzalutamide - Oral Oncology

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Epoetin Alfa - ESRD

Products Affected

- PROCRIT
- RETACRIT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, dialysis status (only if diagnosis of end-stage renal disease)
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For a diagnosis of end stage renal disease on dialysis, CMS expects that this drug should routinely be provided by a dialysis center and billed to Medicare Part B as part of a bundled payment arrangement (if applicable). All other diagnoses unrelated to end stage renal disease on dialysis would be evaluated for coverage under the Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erdafitinib - Oral Oncology

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erenumab - CGRP Antagonists

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	For episodic or chronic migraine headache,patient must have tried and failed two different classes of medications supported by compendia for the prophylactic treatment of migraine headache (such as amitriptyline, divalproex sodium, propranolol, timolol, topiramate, or venlafaxine). Eight-week trials of each of the two medications is required unless intolerance was the reason for clinical failure. Upon recertification, prescriber must attest to the clinical response to treatment, defined as a reduction in the number of migraine headache days per month compared to pre-treatment. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ESRD - Calcium Acetate

Products Affected

- *calcium acetate(phosphat bind)*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, dialysis status (only if diagnosis of end-stage renal disease)
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For a diagnosis of end stage renal disease on dialysis, CMS expects that this drug should routinely be provided by a dialysis center and billed to Medicare Part B as part of a bundled payment arrangement (if applicable). All other diagnoses unrelated to end stage renal disease on dialysis would be evaluated for coverage under the Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ESRD - Lanthanum Carbonate

Products Affected

- *lanthanum*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, dialysis status (only if diagnosis of end-stage renal disease)
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For a diagnosis of end stage renal disease on dialysis, CMS expects that this drug should routinely be provided by a dialysis center and billed to Medicare Part B as part of a bundled payment arrangement (if applicable). All other diagnoses unrelated to end stage renal disease on dialysis would be evaluated for coverage under the Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ESRD - Sevelamer

Products Affected

- *sevelamer carbonate*
- *sevelamer hcl*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, dialysis status (only if diagnosis of end-stage renal disease)
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For a diagnosis of end stage renal disease on dialysis, CMS expects that this drug should routinely be provided by a dialysis center and billed to Medicare Part B as part of a bundled payment arrangement (if applicable). All other diagnoses unrelated to end stage renal disease on dialysis would be evaluated for coverage under the Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ESRD - Sucroferric Oxyhydroxide

Products Affected

- VELPHORO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, dialysis status (only if diagnosis of end-stage renal disease)
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For a diagnosis of end stage renal disease on dialysis, CMS expects that this drug should routinely be provided by a dialysis center and billed to Medicare Part B as part of a bundled payment arrangement (if applicable). All other diagnoses unrelated to end stage renal disease on dialysis would be evaluated for coverage under the Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Etanercept

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	For all shared indications, patient must try ONE formulary adalimumab biosimilar (Hadlima or Simlandi) before approval of Enbrel. If contraindication to Hadlima AND Simlandi, then a trial with one of these is not required before approval of Enbrel. Enbrel will also be approved for patients with documented inadequate response after a trial with any previous adalimumab product. Enbrel is covered without additional step through formulary adalimumabs for all FDA approved indications of Enbrel not shared by Hadlima and Simlandi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Etrasimod

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a Gastroenterologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of moderately to severely active Ulcerative Colitis in patients who have failed to have an adequate response to or had an intolerance to two American Gastroenterological Association (AGA) higher efficacy agents such as Rinvoq and Skyrizi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Everolimus - Oral Oncology

Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet for suspension 2 mg, 3 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fecal Microbiota Spores, Live

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Must have a stool test positive for toxigenic Clostridioides difficile within the past 30 days.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a gastroenterologist or infectious diseases specialist.
Coverage Duration	One month.
Other Criteria	Covered for prevention of Clostridioides difficile infection (CDI) in patients who have had at least 2 recurrent episodes of CDI. Must have completed an antibiotic course for the treatment of CDI two to four days before initiation of treatment with Vowst. Patient must not be immune compromised. Retreatment with Vowst for the same CDI will not be covered. Vowst will not be covered for the treatment of active CDI. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fedratinib - Oral Oncology

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fenfluramine

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Finerenone

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for chronic kidney disease associated with type 2 diabetes in patients with inadequate response, intolerance, or contraindication to an ACE-I or ARB. Covered for heart failure with left ventricular ejection fraction greater than or equal to 40% in patients with inadequate response, intolerance, or contraindication to an ACE-I or ARB AND an SGLT2.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fruquintinib - Oral Oncology

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Futibatinib - Oral Oncology

Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gabapentin - Gabapentin ER

Products Affected

- *gabapentin oral tablet extended release 24 hr*
  300 mg, 450 mg, 600 mg, 750 mg, 900 mg

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	For the treatment of post-herpetic neuralgia, there must be documentation of intolerance or contraindication to generic immediate-release gabapentin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ganaxolone

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	One year
Other Criteria	Covered for the treatment of seizures associated with Cyclin-Dependent Kinase-Like 5 (CDKL5) deficiency disorder confirmed by CDKL5 genetic testing in patients 2 years of age and older. Recertification will require either (1) documentation of a sustained reduction in monthly seizure frequency compared to baseline or (2) subjective or objective evidence from provider that use of Ztalmy has improved the patient's condition. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gefitinib - Oral Oncology

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gepirone - Behavioral Health

Products Affected

- EXXUA ORAL TABLET EXTENDED RELEASE 24 HR
- EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For MAJOR DEPRESSIVE DISORDER (MDD), coverage of Exxua requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment indicated for MDD (such as SSRIs, SNRIs, bupropion, mirtazapine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gilteritinib - Oral Oncology

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Glasdegib - Oral Oncology

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Glecaprevir/Pibrentasvir

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Mavyret will not be covered in patients with moderate or severe hepatic impairment (Child-Pugh B or C). Mavyret will not be covered for genotypes that are not supported by its FDA approved indication, compendia, or AASLD guidelines.
Required Medical Information	Diagnosis, pertinent lab/diagnostic test results including baseline HCV RNA results and HCV genotype, and documentation of current and previous therapies (if applicable).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a gastroenterologist, hepatologist, infectious disease specialist, or HCV/HIV specialist
Coverage Duration	8 to 16 weeks (depending on diagnosis, FDA approved labeling, and AASLD/IDSA guidance)
Other Criteria	For off-label Mavyret reviews, criteria will be applied consistent with compendia and current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Glutamine

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a hematologist
Coverage Duration	One year.
Other Criteria	Covered for reducing the acute complications of sickle cell disease, including symptomatic pain relief. Patient must have experienced inadequate pain relief with a minimum three-month trial or a hematologic toxicity reaction with hydroxyurea monotherapy. Hematologic toxicity with hydroxyurea is defined by neutrophil, platelet, hemoglobin and/or reticulocyte count abnormalities concurrent with hydroxyurea. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Halobetasol/Tazarotene - Topical Psoriasis Combos

Products Affected

- DUOBRII

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for a diagnosis of psoriasis. In addition, there must be lack of clinical response or intolerance to one generic topical steroid AND either a generic topical vitamin D analog or a generic topical retinoid. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Iberdomide - Oral Oncology

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ibrutinib - BTKi

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis and previous therapies used for requested condition, if any
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Imbruvica 140 mg and 280mg TABLETS will not be covered unless there is a market availability issue with Imbruvica 140 mg CAPSULES, which have a quantity limit that allows for labeled dosing for all indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Icatibant - Acute HAE

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for the prophylaxis of hereditary angioedema attacks.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by allergist, immunologist, hematologist, or dermatologist
Coverage Duration	One year
Other Criteria	Covered for a confirmed diagnosis of HAE Type 1, Type II, or Type III for the treatment of acute hereditary angioedema attacks. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Idelalisib - Oral Oncology

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iloperidone - Behavioral Health

Products Affected

- FANAPT
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B
- FANAPT TITRATION PACK C

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For BIPOLAR DISORDER, coverage of Fanapt requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). For SCHIZOPHRENIA, coverage of Fanapt requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Imatinib - Oral Oncology

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*
- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imlunestrant - Oral Oncology

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Immunoglobulin G - IVIG

Products Affected

- GAMMAGARD LIQUID
- GAMMAGARD LIQUID ERC
- GAMMAKED
- GAMUNEX-C
- OCTAGAM
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	Excluded under Part D if intravenous immune globulin (IVIG) is provided in the home for individual with diagnosis of primary immune deficiency disease.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results. For immune thrombocytopenic purpura (ITP), submission of platelet count with the requirement with a requirement it is less than 30,000/mcL or less than 50,000/mcL with documented increased risk of bleeding.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Two years for chronic conditions. One month for acute conditions. 5 days for Guillain-Barre
Other Criteria	Requests will be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Immunoglobulin G - SCIG

Products Affected

- HIZENTRA
- HYQVIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Two years for chronic conditions. One month for acute conditions. 5 days for Guillain-Barre.
Other Criteria	Requests will be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inavolisib - Oral Oncology

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Infliximab

Products Affected

- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a Gastroenterologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of moderately to severely active Crohn's Disease in patients with a documented failure of two American Gastroenterological Association (AGA) higher efficacy agents: Hadlima, Rinvoq, Selarsdi, Simlandi, Skyrizi, Yesintek. Covered for the treatment of moderately to severely active Ulcerative Colitis (UC) in patients who have failed to have an adequate response to or had an intolerance to two AGA higher efficacy agents such as Rinvoq and Skyrizi. For those already established on maintenance IV infliximab, no prerequisite is required. DOSING for CD and UC: Approved for 120mg every 2 weeks as maintenance therapy after IV induction. For CD: Dose escalation to 120mg weekly or 240mg every 2 weeks (4ml per 28 days) will be approved if converting from high-dose IV maintenance therapy (eg, 10 mg/kg IV every 4 weeks) or in patients who experience breakthrough symptoms on lower SUBQ maintenance doses. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Interferon Gamma-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Istradefylline - Parkinson's

Products Affected

- NOURIANZ

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	For the treatment of off episodes in Parkinson's disease Nourianz is covered for patients who have documentation of a contraindication, inadequate response, or intolerance to TWO generic anti-Parkinson's disease drugs with different mechanisms of action. Examples include COMT inhibitors (entacapone and tolcapone), dopamine agonists (pramipexole, ropinirole, amantadine, and bromocriptine), MAO B-inhibitors (rasagiline and selegiline), and anticholinergics (benztropine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ivacaftor

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will be excluded in patients with cystic fibrosis who are homozygous for the F508 del mutation in the CFTR gene.
Required Medical Information	Diagnosis, lab/diagnostic results to include testing for CFTR gene mutation that is responsive to ivacaftor
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ivacaftor/Lumacaftor

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will be excluded in patients with Cystic Fibrosis who are not homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic results to include testing that shows two copies of the F508 del mutation in the conductance regulator (CFTR) gene.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ivacaftor/Tezacaftor

Products Affected

- SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N)

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will be excluded in patients that lack the required genetic mutation(s) targeted by the medication.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic results to include testing that shows either two copies of the F508 del mutation in the conductance regulator (CFTR) gene or at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor (Symdeko). Responsive mutations are those outlined in FDA labeling.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ivosidenib - Oral Oncology

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ixazomib - Oral Oncology

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ketoconazole

Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Excluded for individuals with pituitary or adrenal carcinoma and will not be covered for a treatment of fungal infections.
Required Medical Information	Diagnosis, mean urinary free cortisol (UFC) level measured over three 24-hour measurements, current and previous therapies used for the treatment of the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of endogenous Cushing's syndrome in patients with documentation of clinical symptoms (such as diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression, and anxiety) who have a mean urinary free cortisol (UFC) level that is at least 1.5x the upper limit of normal (ULN) measured over three 24-hour measurements (ULN = 50 mcg/24 hours or 138 nmol/24 hours). Also, there must be documentation of failure of or contraindication to Cushing's syndrome-specific surgery as well as serious side effects or drug failure with oral ketoconazole. For patients with a diagnosis of Cushing's Disease (Cushing's Syndrome that is caused by a pituitary adenoma), documentation of trial and failure or serious side effects with Signifor/pasireotide must be provided. Recertification at 6 months and yearly thereafter will require laboratory results to document a recent UFC level within normal limits AND improvement in symptoms of Cushing's Syndrome. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lacosamide

Products Affected

- MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of partial-onset seizures and as adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in patients weighing at least 50 kg. In addition, there must be documentation of severe intolerance, contraindication to or the inability to take immediate release lacosamide. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lanadelumab - Prophylactic Hereditary Angioedema (HAE)

Products Affected

- TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150 MG/ML)

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for acute hereditary angioedema attacks.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by allergist, immunologist, hematologist, or dermatologist
Coverage Duration	One year
Other Criteria	Covered for a confirmed diagnosis of HAE type 1, type II, or type III. Prophylactic therapy will be covered for individuals whose provider has determined that prophylactic therapy is medically necessary, after consideration of such factors as disease burden, activity of disease, frequency of attacks, patient preference, quality of life, and availability of healthcare resources. Objective and/or subjective documentation of these considerations must be provided. Recertification requires objective and/or subjective evidence of clinical benefit from use of the drug. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lapatinib - Oral Oncology

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Larotrectinib - Oral Oncology

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lazertinib - Oral Oncology

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lecanemab

Products Affected

- LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML, 500 MG/2.5 ML (250MG/1.25MLX2)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Documentation of all of the following: amyloid-beta pathology consistent with AD, positive brain amyloid biomarker confirmed by amyloid PET scan or CSF testing, baseline brain MRI completed within previous 12 months to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA), MMSE score 21-30. Documentation of at least one validated cognitive assessment supporting diagnosis, such as Montreal Cognitive Assessment Test (MoCA), Alzheimer Disease Assessment Scale-Cognitive subscale 14 (ADAS-Cog 14), Saint Louis University Mental Status Examination (SLUMS), Self-Administered Gerocognitive Exam (SAGE), or Clinical Dementia Rating (CDR) Global Score 0.5-1.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a geriatrician, neurologist, geriatric psychiatrist, or Dementia and Alzheimer's disease specialist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of Alzheimer's disease in patients with mild cognitive impairment (MCI) or mild dementia stage of disease. Patients must have a mini mental state examination (MMSE) score of 21-30 and meet baseline cognitive score thresholds in one additional cognitive assessment tool. Recertification requires prescriber attestation that patient has been evaluated for evidence of amyloid-related imaging abnormalities (ARIA) on MRI within approximately one week prior to the 3rd, 5th, 7th, and 14th dose AND the patient has a positive clinical response as evidenced by stabilization or slowing of disease progression, either subjective or by repeat assessment cognitive tool used on initial submission (patient has not progressed to moderate or severe AD).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenalidomide - Oral Oncology

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenvatinib - Oral Oncology

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Leuprolide - Gonadotropin Releasing Hormone Analogs

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- *leuprolide subcutaneous kit*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	6 months for endometriosis. One year for all other diagnoses.
Other Criteria	Lupron/leuprolide is covered for management of endometriosis, including pain relief and reduction of endometriotic lesions. Authorization will be for up to 6 months, because of a lack of safety data with long term use and concerns regarding effects on bone density. Lupron/leuprolide is covered for treatment of advanced prostate cancer, defined as stage III or stage IV. Lupron/leuprolide is covered for treatment of precocious puberty. Lupron/leuprolide is covered as adjunct therapy for preoperative hematologic improvements of patients with anemia (hematocrit less than or equal to 30% and/or hemoglobin less than or equal to 10.2 g/dL) caused by uterine leiomyomata. Eligard is covered for palliative treatment of advanced prostate cancer. Requests will also be evaluated for off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Levodopa - Parkinson's

Products Affected

- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	For the treatment of off episodes in Parkinson's disease Inbrija is covered for patients who have documentation of a contraindication, inadequate response, or intolerance to TWO generic anti-Parkinson's disease drugs with different mechanisms of action. Examples include COMT inhibitors (entacapone and tolcapone), dopamine agonists (pramipexole, ropinirole, amantadine, and bromocriptine), MAO B-inhibitors (rasagiline and selegiline), and anticholinergics (benztropine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lidocaine - Lidocaine Patch

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lorlatinib - Oral Oncology

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lotilaner

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Microscopic examination of eyelashes showing Demodex mites.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an ophthalmologist.
Coverage Duration	Two months.
Other Criteria	Must have a diagnosis of Demodex blepharitis confirmed by microscopic examination of the eyelashes to detect Demodex mites. Must have bothersome symptoms of Demodex blepharitis (such as itchy eyelids, excessive eye tearing, light sensitivity, gritty or burning eye sensation). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lumateperone - Behavioral Health

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For BIPOLAR DISORDER, coverage of Caplyta requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). For MAJOR DEPRESSIVE DISORDER (MDD), coverage of Caplyta requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment indicated for MDD (such as SSRIs, SNRIs, bupropion, mirtazapine). For SCHIZOPHRENIA, coverage of Caplyta requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Macitentan - Pulmonary Arterial Hypertension (PAH)

Products Affected

- *macitentan*
- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, Opsumit requires a trial with a generic ERA (ambrisentan, bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Macitentan/Tadalafil - Pulmonary Arterial Hypertension (PAH)

Products Affected

- OPSYNVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, Opsynvi requires a trial with a generic ERA (ambrisentan, bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Maralixibat

Products Affected

- LIVMARLI ORAL SOLUTION
- LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Genetic testing confirming Alagille Syndrome (ALGS) or progressive familial intrahepatic cholestasis (PFIC) is required. Note: per FDA-approved prescribing information, Livmarli is not recommended in a subgroup of PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein. Therefore, Livmarli will not be approved for this subgroup of patients. Evidence of cholestasis (ONE of the following) must be provided: 1) total serum bile acid greater than the ULN for age, or 2) increased conjugated bilirubin levels or 3) otherwise unexplainable fat-soluble vitamin deficiency, or 4) gamma glutamyl transferase (GGT) greater than the ULN for age or 5) intractable pruritus explainable only by liver disease.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by provider experienced with the management of ALGS or PFIC.
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Covered for treatment of cholestatic pruritus in patients with genetic testing confirmed ALGS. Covered for treatment of cholestatic pruritus with PFIC. For either indication, objective and/or subjective evidence of significant pruritus must be submitted by provider. Evidence of cholestasis must be provided (as described in required medical information). Recertification requires documentation of a decrease in pruritus from baseline and/or decrease in serum bile acid concentration from baseline. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mecasermin

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Increlex will not be covered for growth promotion in patients with closed epiphyses or as a substitute for growth hormone replacement therapy. IV administration will not be covered.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results (such as IGF-1 levels and GH levels).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist, pediatric endocrinologist, or nephrologist.
Coverage Duration	One year
Other Criteria	Increlex will be covered in patients with severe primary IGF-1 deficiency defined as height SD score less than -3.0, basal IGF-1 SD score less than -3.0, and normal or elevated GH. They will also be covered in patients with growth hormone (GH) gene deletion with the development of neutralizing antibodies to GH. Normal dose is 40-120mcg/kg sq twice daily given 20 minutes before or after a meal or snack to avoid hypoglycemia. Doses greater than 120mcg/kg will not be covered.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mechlorethamine

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent lab/diagnostic tests used to confirm diagnosis, current and/or previous skin-directed therapy.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or dermatologist.
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Methamphetamine

Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for weight loss, even if non-cosmetic (such as morbid obesity).
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MethylNaltrexone - Opioid-Induced Constipation

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for the treatment of opioid-induced constipation with documented lack of response or severe intolerance to generic lubiprostone or Movantik. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Metreleptin

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	Use of Myalept is excluded for the following conditions: metabolic disease not associated with congenital leptin deficiency, HIV-associated lipodystrophy
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for the treatment of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. Diagnosis is confirmed through low serum leptin levels and the absence of subcutaneous fat.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Midostaurin - Oral Oncology

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mifepristone - Korlym

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded in patients who are pregnant, who have a history of unexplained vaginal bleeding/endometrial changes, who are currently receiving long-term corticosteroids, or who are currently on simvastatin, lovastatin or a medication that is a CYP3a substrate and has a narrow therapeutic range.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic test results (such as HbA1c levels and negative pregnancy test in women of childbearing age), and documentation of previous therapies (failure of surgery or not a candidate for surgery).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year
Other Criteria	Covered in patients with a diagnosis of endogenous Cushing's syndrome and Type 2 diabetes or glucose intolerance. Patients must have failed surgery or not be a candidate for surgery. Women of childbearing age must have a negative pregnancy test prior to starting therapy and must not be nursing. Non-hormonal contraception must be used while on therapy, unless the patient has had a surgical sterilization, in which case, no additional contraception is needed. Hypokalemia should be corrected prior to treatment and monitored for during treatment. Patients should also be closely monitored for signs and symptoms of adrenal insufficiency. Recertification after one year will require the submission of patient progress notes and lab work that demonstrates clinical response or stabilization of disease. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mirdametinib - Oral Oncology

Products Affected

- GOMEKLI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mitapivat

Products Affected

- PYRUKYND ORAL TABLET 20 MG, 5 MG, 5 MG (4-WEEK PACK), 50 MG
- PYRUKYND ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Also, Pyrukynd will not be covered for patients who are homozygous for the c.1436G to A (p.R479H) variant or have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a hematologist, geneticist, or provider who specializes in pyruvate kinase (PK) deficiency
Coverage Duration	6 months
Other Criteria	Covered for patients with a diagnosis of pyruvate kinase deficiency hemolytic anemia defined as having documented presence of at least 2 mutant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, one of which is a missense mutation. Baseline hemoglobin must be less than or equal to 10 g/dL OR have had more than 4 red blood cell (RBC) transfusions in the last year. Recert requires ONE of the following: a) improvement in hemoglobin level from baseline OR b) Reduction in the number of RBC transfusions while receiving Pyrukynd OR c) Laboratory evidence demonstrating improvement in markers of hemolysis (i.e., indirect bilirubin, lactate dehydrogenase (LDH), haptoglobin), OR d) other subjective or objective evidence from provider that use of Pyrukynd has improved the patient's condition. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Modafinil - Sleep Disorders

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, sleep study results, and documentation of outcome with previous therapies attempted for the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or sleep specialist for a diagnosis of cataplexy or excessive daytime sleepiness associated with narcolepsy. Must be prescribed by a neurologist, sleep specialist, or pulmonologist for a diagnosis of Excessive Daytime Sleepiness associated with Obstructive Sleep Apnea.
Coverage Duration	One year
Other Criteria	Modafinil is covered for a diagnosis of excessive daytime sleepiness associated with narcolepsy, excessive daytime sleepiness associated with obstructive sleep apnea (OSA), and shift-work disorder. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Momelotinib - Oral Oncology

Products Affected

- OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Neratinib - Oral Oncology

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nilotinib - Oral Oncology

Products Affected

- CAVHANZA
- *nilotinib hcl*
- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nintedanib

Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Computed tomography (CT) scan report, pulmonary function test (PFT) showing FVC values, documentation of previous & current therapies.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For a diagnosis of Idiopathic Pulmonary Fibrosis, must be prescribed by a Pulmonologist. For Systemic Sclerosis-Associated Interstitial Lung disease with declining pulmonary function or chronic fibrosing interstitial lung diseases with a progressive phenotype, must be prescribed by a Pulmonologist or Rheumatologist.
Coverage Duration	One year.
Other Criteria	Covered for a documented diagnosis of idiopathic pulmonary fibrosis. Covered for a diagnosis of systemic sclerosis-associated interstitial lung disease (SSC-ILD) with declining pulmonary function or a diagnosis of chronic fibrosing interstitial lung diseases with a progressive phenotype when HRCT scan conducted within the past 12 months shows fibrosis affecting at least 10% of the lungs. For SSC-ILD, the patient must have failed to respond to or been intolerant of mycophenolate mofetil. For chronic fibrosing interstitial lung diseases with a progressive phenotype, patient must have clinical signs of progression (defined as FVC decline at least 10% or FVC decline at least 5% with worsening symptoms or imaging). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Niraparib - Oral Oncology

Products Affected

- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nirogacestat - Oral Oncology

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nitisinone

Products Affected

- HARLIKU
- *nitisinone*
- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a physician specializing in the treatment of Tyrosinemia type 1 (such as a metabolic disease specialist).
Coverage Duration	One year.
Other Criteria	Nitisinone capsules and Nityr tablets are covered for patients with a diagnosis of hereditary tyrosinemia type 1. Patients must have the presence of succinylacetone (SSA) in the urine or blood / dried blood spots. Patients must have clinical features of tyrosinemia type 1, such as: failure to thrive, emesis, melena, hepatosplenomegaly, liver disease, cirrhosis, clotting abnormalities, renal disease/Fanconi syndrome, neurological crisis, rickets. Requests for Nityr tablets require documentation of severe intolerance or contraindication of the preferred product generic nitisinone capsules. Harliku tablets are covered for the reduction of urine homogentisic acid (HGA) in adult patients with alkaptonuria (AKU).Diagnosis must be confirmed by an elevated urinary HGA excretion and HGC plasma concentration at baseline. Recertification requires documentation of improvement from baseline(s) OR sustained clinical benefits. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Odevixibat

Products Affected

- BYLVAY

PA Criteria	Criteria Details
Exclusion Criteria	Clinical evidence of decompensated cirrhosis and as limited by FDA labeling.
Required Medical Information	Diagnosis of Alagille syndrome or PFIC confirmed by genetic testing, objective and/or subjective provider assessment of baseline pruritus severity.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a hepatologist, gastroenterologist, or physician knowledgeable in the management of progressive familial intrahepatic cholestasis (PFIC).
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Covered for the treatment of cholestatic pruritus in patients at least 12 months of age who have Alagille syndrome with confirmed mutations in the JAG1 or NOTCH2 gene. Covered for treatment of pruritus due to progressive familial intrahepatic cholestasis (PFIC). Recertification for both indications requires documentation that the patient is tolerating therapy and is experiencing a decrease in pruritus from baseline based on objective and/or subjective assessment from provider. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Olanzapine/Samidorphan

Products Affected

- LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for patients using opioids or undergoing acute opioid withdrawal.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or psychiatrist.
Coverage Duration	One year.
Other Criteria	Coverage requires documentation of one of the following: (1) at least a 4-week trial with generic olanzapine that yielded beneficial stable clinical response but unacceptable weight gain (unacceptability as determined by provider with attribution to side effect of olanzapine), or (2) significant intolerance or therapeutic failure of two generic first-line treatments (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Olaparib - Oral Oncology

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Olutasidenib - Oral Oncology

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Omalizumab

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	Xolair is excluded in patients weighing over 150kg. Xolair will not be covered for the treatment of atopic dermatitis.
Required Medical Information	Diagnosis, pertinent lab/diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an allergist, dermatologist, immunologist, otolaryngologist, or pulmonologist.
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.

PA Criteria	Criteria Details
Other Criteria	For all shared indications, approval of Xolair requires intolerance, therapeutic failure or contraindication to Dupixent. Covered for the treatment of MODERATE TO SEVERE PERSISTENT ASTHMA. For ages 12 and older, pt. must be experiencing asthma exacerbations, and must have baseline IgE levels between 30 and 700 iu/ml. For patients ages 6 to less than 12, must be experiencing asthma exacerbations and the patient must have baseline IgE levels between 30 and 1300 iu/ml. Patient must have documented evidence of at least 1 perennial aeroallergen (e.g., house dust mite [dermatophagoides farinae, d. Pteronyssinus], animal dander (dog, cat), cockroach, feathers, mold spores) by skin test or in vitro testing. The patient must be maintained on asthma treatment consistent with the GINA or NHLBI guidelines, which recommend the combination of a high-dose inhaled steroid with a long-acting beta agonist (preferred by GINA guidelines), or leukotriene inhibitor, or long-acting muscarinic antagonist, or theophylline. Upon recertification, documentation should be provided validating reduction in asthma exacerbations. Covered for the diagnosis of CHRONIC SPONTANEOUS URTICARIA in patients that have experienced at least a six-week history of urticaria, characterized by the development of pruritic wheals (hives), angioedema, or both. In addition, the patient must have a documented history of symptomatic failure of H1 antihistamine treatment and intolerance, therapeutic failure or contraindication to Dupixent. Upon recertification, documentation should be provided validating response to therapy (such as decreased severity of itching, decreased size of hives, decreased number of hives). Covered for a diagnosis of CHRONIC RHINOSINUSITIS WITH NASAL POLYPS with documentation of inadequate response to an 8 week trial of Xhance nasal spray and intolerance, therapeutic failure or contraindication to Dupixent. Recertification will require documentation of continued use of intranasal corticosteroid and clinical benefit from Xolair use (e.g., reduced polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell). Covered for the treatment of IgE-MEDIATED FOOD ALLERGY in patients with single or multiple IgE-mediated food allergies. Patient must have documented positive skin prick test, allergen-specific IgE, and/or oral food challenge included. Requests will also be evaluated for Part B vs Part D coverage and off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Omaveloxolone

Products Affected

- SKYCLARYS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic/genetic test results. Baseline modified Friedreichs Ataxia Rating Scale (mFARS) score must be provided.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or prescriber knowledgeable in the management of Friedreichs ataxia (FA).
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of Friedreichs ataxia confirmed by genetic testing. In addition, the patient must exhibit clinical manifestations of disease (e.g., muscle weakness, decline in coordination, frequent falling). Recertification requests will require documentation that the patient has had a clinical benefit from therapy (e.g., slowed decline in limb coordination) OR patient has had a reduction in modified Friedreichs Ataxia Rating Scale (mFARS) score of at least 1.5 points from baseline OR provider attestation that the patient continues to benefit from therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Onabotulinumtoxina - Botox

Products Affected

- BOTOX

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Excluded for cosmetic uses.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests will be evaluated for Part B vs Part D coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Osilodrostat

Products Affected

- ISTURISA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, mean urinary free cortisol (UFC) level measured over three 24-hour, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of endogenous hypercortisolemia in adults with Cushing syndrome with documentation of clinical symptoms (such as diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression, or anxiety) who have a mean urinary free cortisol (UFC) level that is at least 1.5x the upper limit of normal measured over three 24-hour measurements (ULN = 50 mcg/24 hours or 145 nmol/24 hours). Also, there must be documentation of a failed pituitary surgery OR contraindication to pituitary surgery. In those patients with Cushing Disease (Cushing Syndrome that is caused by a pituitary adenoma), there must also be intolerance or drug failure with Signifor/pasireotide. A dose increase request will require both documentation to show UFC levels above the upper limit of normal on current dose and documentation that the patient is still experiencing Cushing disease symptoms. All dose increases approved for 3 months. Recertification of the same dose will require both documentation of a recent UFC level within normal limits and documentation of improvement in the symptoms of Cushing disease. Recertifications at same dose as previously approved are approved for 1 year. For all requests, the prescriber must make clear the dose they are planning to use. Recertification at a previously approved dose (maintenance dosing) will allow the dose requested only. Dose increases must be in accordance with FDA labeling and titrated by no greater than 1 mg or 2 mg twice daily, no more frequently than every 2 weeks based on the rate of cortisol changes, individual tolerability, and improvement in signs and symptoms. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Osimertinib - Oral Oncology

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Oteseconazole

Products Affected

- VIVJOA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. Vivjoa is contraindicated in those who have the ability to become pregnant, are pregnant, or are lactating.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Limited to one treatment course (14 weeks) per year.
Other Criteria	Covered for a diagnosis of recurrent vulvovaginal candidiasis (RVVC) in females with a history of RVVC who are not of reproductive potential. Females who are not of reproductive potential are defined as persons who are biological females who are postmenopausal or have another reason for permanent infertility (e.g. tubal ligation, hysterectomy, salpingo-oophorectomy). The patient must have had 3 or more symptomatic acute episodes of VVC within the past 12 months and must have a KOH stain or other positive diagnostic culture test for this recurrence. In addition, the patient must have experienced an adverse reaction or treatment failure of oral fluconazole at a dosing regimen appropriate for diagnosis of RVVC, unless patient has adverse reaction or contraindication to fluconazole. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Oxybate - Sodium Oxybate

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, sleep study results, and documentation of outcome with previous therapies attempted for the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or sleep specialist for a diagnosis of cataplexy or excessive daytime sleepiness associated with narcolepsy.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of cataplexy associated with narcolepsy. Covered for the treatment of excessive daytime sleepiness associated with narcolepsy without cataplexy in pediatric patients less than 18 years of age. Covered for the treatment of excessive daytime sleepiness associated with narcolepsy without cataplexy in adults that have failed or had an intolerance to both armodafinil AND modafinil.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pacritinib - Oral Oncology

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Palbociclib - CDK 4/6

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pasireotide

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis. For the diagnosis of Cushings disease, there must be pertinent lab/diagnostic test results, which include a mean urine free cortisol (mUFC) level at baseline and upon recertification. Confirmation from provider that patient is not a candidate for surgery or that previous surgery was not effective. A non-surgical candidate is defined as either having a medical contraindication to surgery or having a tumor which is surgically unapproachable.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year.
Other Criteria	After 3 months of therapy for a diagnosis of Cushings disease, patient must demonstrate a reduction in mUFC compared to baseline. Subsequent authorizations will be for 12 months with continued signs of efficacy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pazopanib - Oral Oncology

Products Affected

- *pazopanib oral tablet 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pegvisomant - Acromegaly Therapy

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Documentation patient has had an inadequate response to surgery or radiation. Current and previous therapies for acromegaly.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For ACROMEGALY, must be prescribed by an endocrinologist.
Coverage Duration	One year.
Other Criteria	For the treatment of acromegaly, patients must have had a contraindication, inadequate response, or severe intolerance to/serious side effects from generic injectable octreotide.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Pemigatinib - Oral Oncology

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pertuzumab/Trastuzumab/Hyaluronidase - Injectable Oncology

Products Affected

- PHESGO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pexidartinib - Oral Oncology

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pimavanserin

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	Per the black box warning on Nuplazid, elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Therefore, Nuplazid will not be covered for elderly patients with dementia-related psychosis.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist, psychiatrist, or geriatrician
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pirfenidone - Esbriet

Products Affected

- *pirfenidone oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic test results to confirm diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist.
Coverage Duration	One year
Other Criteria	Covered for a documented diagnosis of idiopathic pulmonary fibrosis.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pirtobrutinib - BTKi

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis and previous therapies used for requested condition, if any
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. For shared indication CLL/SLL, approval of Jaypirca/pirtobrutinib requires intolerance or contraindication to Calquence/acalabrutinib AND Imbruvica/ibrutinib. For shared indication MANTLE CELL LYMPHOMA, approval of Jaypirca/pirtobrutinib requires intolerance or contraindication to Calquence/acalabrutinib. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Plozasiran

Products Affected

- REDEMPLO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Must have a diagnosis of Familial Chylomicronemia Syndrome (FCS) and have fasting triglycerides (TGs) of 880 mg/dL (or 10 mmol/L) or greater within the past 6 months. Must provide genetic testing showing biallelic pathogenic variants (i.e., homozygosity, compound heterozygosity or double heterozygosity) in FCS-causing genes. If genetic testing is inconclusive, then must provide one of the following: (1) FCS score of at least 10 OR (2) NAFCS score of at least 45 OR (3) all of the following: inadequate response to standard TG therapy (e.g., statins, fibrates, high-dose omega-3 FA), AND other causes ruled out (e.g., alcohol excess, uncontrolled type 2 diabetes, medications known to raise TG), AND either history of acute pancreatitis or history or recurrent abdominal pain of unknown cause.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist.
Coverage Duration	Initial approval - 6 months. Recert approval - 1 year.
Other Criteria	Covered as an adjunct to diet, for patients with a diagnosis of Familial Chylomicronemia Syndrome (FCS). Must have documentation or prescriber attestation that the patient has implemented appropriate dietary fat restrictions (e.g., consuming less than 20 g of fat per day) to manage FCS. Recertifications will require documentation of reduction in fasting triglycerides (TGs) from baseline. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pomalidomide - Oral Oncology

Products Affected

- *pomalidomide*
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ponatinib - Oral Oncology

Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pralsetinib - Oral Oncology

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Quinine

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for the treatment of leg cramps.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	Quinine sulfate is covered for the treatment of malaria infections.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Quizartinib - Oral Oncology

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Regorafenib - Oral Oncology

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Relacorilant - Oral Oncology

Products Affected

- LIFYORLI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Relugolix

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist, hematologist or for prostate cancer, a urologist.
Coverage Duration	One year.
Other Criteria	Orgovyx will be covered for patients with advanced Prostate Cancer who have a contraindication (such as high risk for cardiovascular [CV] events or a history of CV events) or had serious side effects to two of the following: degarelix (Firmagon), leuprolide (Lupron/Eligard), or triptorelin/Trelstar. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Repotrectinib - Oral Oncology

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Resmetiron

Products Affected

- REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	Decompensated cirrhosis and as limited by FDA labeling.
Required Medical Information	Pertinent lab and diagnostic imaging results. Prescriber attestation patient has been counseled on comprehensive lifestyle modification (i.e., nutrition, exercise, reduced alcohol consumption, and behavior modification) and documentation that comorbid metabolic conditions are being treated including current therapies used as standard of care (i.e., current therapy for hypertension or hypertriglyceridemia if that is the metabolic condition in patient).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist, gastroenterologist, or hepatologist.
Coverage Duration	One year.
Other Criteria	Covered for the diagnosis of non-cirrhotic metabolic dysfunction associated steatotic liver disease (MASLD) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis). Diagnosis must be confirmed by one of the following: (1) serum biomarkers (i.e., FIB-4 index, NAFLD fibrosis score, ELF test) AND an imaging biomarker such as Elastography [examples include, but are not limited to, vibration-controlled transient elastography (VCTE) {e.g., FibroScan}, transient elastography (TE), magnetic resonance elastography (MRE), acoustic radiation force impulse (ARFI) imaging, shear wave elastography (SWE), magnetic resonance imaging-derived proton density fat fraction (MRI-PDFF)] OR (2) liver biopsy showing non-alcoholic fatty liver disease activity score of 4 or greater with a score of 1 or greater in ALL of the following: steatosis, ballooning AND lobular inflammation. Documentation or provider attestation required that the patient has at least ONE of the following metabolic risk factors that are managed according to standard of care: central obesity, hypertension, hypertriglyceridemia, low HDL cholesterol, elevated fasting plasma glucose. For patients with comorbid Type 2 Diabetes and/or obesity, must have had inadequate response or intolerance to a trial of Wegovy injection, unless contraindicated. Recertification requires stable or improving noninvasive liver disease assessment (NILDA), improvement in liver stiffness measure OR subjective or objective evidence from provider that use of Rezdiffra has improved the patient's condition. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Revumenib - Oral Oncology

Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ribociclib - CDK 4/6

Products Affected

- KISQALI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rilonacept

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rimegepant

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a headache or pain specialist or neurologist
Coverage Duration	One year.
Other Criteria	For the acute treatment of migraine headache with or without aura, Nurtec is covered with documentation of trial and failure or severe intolerance to one generic triptan product. Covered for episodic or chronic migraine headache. Recertification for either indication will require documentation that the drug continues to effectively reduce frequency, duration, and/or severity of migraine headaches for the patient. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Riociguat - Pulmonary Arterial Hypertension (PAH)

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, coverage of Adempas for PAH requires trial with a generic formulary phosphodiesterase-5 enzyme inhibitor (PDE5i) (sildenafil, tadalafil) AND a generic formulary endothelin receptor antagonist (ERA) (ambrisentan, bosentan). Adempas is also covered for chronic thromboembolic pulmonary hypertension (CTEPH).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ripretinib - Oral Oncology

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Risankizumab

Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR MG/2.4 ML (150 MG/ML)
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 55 MG/0.37 ML
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of moderately to severely active CROHN's DISEASE. Covered for patients with a diagnosis of moderate to severe chronic PLAQUE PSORIASIS that involves at least 3% body surface area. Covered for the diagnosis of moderate to severe chronic PLAQUE PSORIASIS in patients with less than 3% BSA if the affected area involves the hands, feet, facial, scalp, or genital regions. Patients also must meet ONE of the following criteria: 1) had a 3-month trial of acitretin, methotrexate, or cyclosporine therapy resulting in intolerance or clinical failure OR 2) have tried UVB/coal tar or Psoralen Ultraviolet A (PUVA) Phototherapy for at least 3 months OR 3) have tried and failed (a) treatment with medium and/or high potency topical corticosteroids for at least 1 month AND (b) ONE of these for at least 3 months: anthralin, calcipotriene, or tazarotene. Covered for the treatment of active PSORIATIC ARTHRITIS. Covered for the diagnosis of moderately to severely ULCERATIVE COLITIS. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Risdiplam

Products Affected

- EVRYSDI ORAL RECON SOLN
- EVRYSDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, including supporting labs/diagnostic test results.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a provider who specializes in the treatment of Spinal Muscular Atrophy (SMA) and/or neuromuscular disorders
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of Type I, II, or III Spinal Muscular Atrophy confirmed by targeted mutation analysis showing homozygous deletions of SMN1 gene or homozygous mutation in the SMN1 gene (e.g., biallelic mutations of exon 7) or compound heterozygous mutation in the SMN1 gene (e.g., deletion of SMN1 exon 7 and mutation of SMN1). Patient must have genetic testing confirming 1, 2, 3, or 4 copies of the SMN2 gene. Additionally, progress notes containing results of at least one of the following baseline motor function exams must be provided: a) Hammersmith Infant Neurological exam (HINE) or b) Hammersmith Functional Motor Scale Expanded (HFMSE) or c) Upper Limb Module (ULM) test/Revised Upper Limb Module test (RULM) or d) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) or e) Motor Function Measure 32 (MFM32) or f) Bayley Scales of Infant and Toddler Development- Third Edition gross motor scale (BSID-III) (for infantile-onset disease only). Recertification will require provider attestation of improvement or slowing of disease progression attributed to the use of Evrysdi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Romosozumab

Products Affected

- EVENITY

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, DEXA scan report(s), previous therapies
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year (refer to other criteria section).
Other Criteria	Covered for post-menopausal women at high risk for fracture. The patient must be considered high risk for fracture, which is defined as 1) history of previous osteoporosis-related fracture, 2) T- score of -2.5 SD or less, 3) T-score between -1.0 and -2.5 SD below normal and a FRAX score for hip fracture of 3% or greater or the risk for other bone fracture is 20% or greater. Patient must also have experienced therapeutic failure, severe intolerance or a contraindication to an oral bisphosphonate or be an inappropriate candidate for oral bisphosphonate therapy based on clinical presentation. Therapeutic failure is defined as a decrease in bone mineral density or a fracture while on bisphosphonate therapy. Severe intolerance defined as chest pain, difficulty swallowing, intense abdominal pain or chronic dyspepsia when oral bisphosphonate therapy was taken according to manufacturer recommendations. Oral bisphosphonates may be clinically inappropriate for a patient that is bedridden/unable to sit upright for 30 minutes unsupervised or has esophageal ulcerations, esophageal stricture, Barrett's Esophagitis, or active ulcers. Additionally, patient must have documented severe intolerance or contraindication to generic teriparatide. The FDA approved labeling does not recommend duration to exceed more than 12 monthly doses. Request will also be evaluated for part b versus part d coverage. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Ropeginterferon Alfa-2B

Products Affected

- BESREMI
- BESREMI PEN

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling. If patient is currently taking hydroxyurea, they must transition off by gradual taper and discontinue by week 13.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year
Other Criteria	Covered for patients with a diagnosis of polycythemia vera (PV). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rucaparib - Oral Oncology

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ruxolitinib - Opzelura

Products Affected

- OPZELURA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling, specifically not to be used in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine. Excluded for forms of vitiligo other than nonsegmental.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a dermatologist.
Coverage Duration	Initial 6 months, recert 1 year.
Other Criteria	Covered for a diagnosis of nonsegmental vitiligo in patients for whom a two-month trial with prescription strength generic topical steroids has failed to restore pigmentation to the vitiliginous skin. For patients with vitiliginous skin on the face and/or intertriginous areas where topical steroids would be inappropriate, failure of a two-month trial with topical tacrolimus to restore pigmentation to the vitiliginous skin must be documented. Covered for a diagnosis of atopic dermatitis in patients who have had serious side effects from or drug failure after at least a four-week trial with a prescription strength generic topical steroid. Must also have had serious side effects from or drug failure after at least a six-week trial with either topical tacrolimus or topical pimecrolimus. Recertification for a diagnosis of nonsegmental vitiligo will require documentation of improvement/decrease in affected areas of vitiligo from baseline based on objective and/or subjective assessment from provider. Recertification for atopic dermatitis will require the patient has achieved/maintained a positive clinical response to therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Ruxolitinib - Oral Oncology

Products Affected

- JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sapropterin

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, baseline serum phenylalanine level, current/recent phenylalanine level with each recertification
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Initial approval - 2 months. Recertifications - 1 year.
Other Criteria	Covered as adjunct therapy for patients diagnosed with phenylketonuria (PKU). Initial approval will be for 2 months. Phenylalanine (PHE) levels should be checked one week after initiation of therapy. If PHE levels do not decrease from baseline on a 10mg/kg/day dose, the dose may be increased to 20mg/kg/day. If PHE levels do not decrease from baseline after 2 months, the patient is considered a non-responder and further therapy will not be authorized.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sarilumab

Products Affected

- KEVZARA SUBCUTANEOUS PEN INJECTOR
- KEVZARA SUBCUTANEOUS SYRINGE 200 MG/1.14 ML

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a rheumatologist
Coverage Duration	One year.
Other Criteria	Covered for the diagnosis of moderate to severe RHEUMATOID ARTHRITIS in patients with documented failure to TWO of the following alternatives: Hadlima, Orencia, Rinvoq, Simlandi, Xeljanz/XR. Covered for the diagnosis of POLYMYALGIA RHEUMATICA (PMR) in patients who have had an inadequate response to corticosteroids or who cannot tolerate a corticosteroid taper. Covered for the diagnosis of active POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (pJIA) in patients with documented failure to TWO of the following: : Hadlima, Orencia, Rinvoq, Simlandi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Satralizumab

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) confirmed by a positive anti-aquaporin-4 (AQP4) antibody test (results must be provided).
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an ophthalmologist or neurologist.
Coverage Duration	One year.
Other Criteria	Covered for patients with a diagnosis of Neuromyelitis Optica spectrum disorder (NMOSD) confirmed by a positive anti-aquaporin-4 (AQP4) antibody test. Patient must have had at least 1 Neuromyelitis Optica relapse that required rescue therapy (such as corticosteroids or plasma exchange) in the last 12 months. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Secukinumab

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a dermatologist or rheumatologist
Coverage Duration	One year.
Other Criteria	Covered for the diagnosis of ANKYLOSING SPONDYLITIS in patients with refractory disease defined by failure of at least one NSAID at maximally tolerated dose taken for a minimum one-month duration. Covered for the diagnosis of moderate to severe chronic PLAQUE PSORIASIS with psoriasis that involves at least 3% body surface area (BSA). Covered for the diagnosis of moderate to severe chronic PLAQUE PSORIASIS in patients with psoriasis that involves less than 3% BSA if the affected area involves the hands, feet, scalp, facial or genital regions. Patients also must meet one of the following criteria: 1) had a 3-month trial of acitretin, methotrexate, or cyclosporine therapy resulting in intolerance or clinical failure or 2) have tried UVB/coal tar or PUVA/topical corticosteroids for at least 3 months or 3) have tried and failed at least two of the following for 3 months: treatment with medium and/or high potency topical corticosteroids or anthralin, calcipotriene, or tazarotene. Covered for a diagnosis of PSORIATIC ARTHRITIS. Covered for a diagnosis of NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS. Covered for a diagnosis of moderate to severe HIDRADENITIS SUPPURATIVA (HS). Covered for patients with a diagnosis of ENTHESITIS-RELATED ARTHRITIS who have failed to respond to and/or are intolerant to at least one month of maximally tolerated NSAID therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Selexipag - Pulmonary Arterial Hypertension (PAH)

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 100 MCG, 150 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, coverage of Uptravi for PAH requires trial with a generic formulary phosphodiesterase-5 enzyme inhibitor (PDE5i) (sildenafil, tadalafil) AND a generic formulary endothelin receptor antagonist (ERA) (ambrisentan, bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Selinexor - Oral Oncology

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Selpercatinib - Oral Oncology

Products Affected

- RETEVMO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Selumetinib - Oral Oncology

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Semaglutide - GLP-1 Agonists

Products Affected

- OZEMPIC ORAL
- OZEMPIC SUBCUTANEOUS
- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for weight management and as limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for the treatment of type 2 diabetes mellitus. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Semaglutide - Wegovy

Products Affected

- WEGOVY ORAL
- WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for weight management and as limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	WEGOVY injection is covered when used in combination with a reduced calorie diet and increased physical activity: 1) to reduce the risk of major adverse cardiovascular (CV) events (CV death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established CV disease and either obesity or overweight, OR 2) to reduce excess body weight and maintain weight reduction long term in adults and pediatric patients aged 12 years and older with obesity, OR 3) adults with overweight in the presence of at least one weight-related comorbid condition, OR 4) for the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)/nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults. WEGOVY tablets are covered when used in combination with a reduced calorie diet and increased physical activity: 1) to reduce the risk of major adverse CV events (CV death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established CV disease and either obesity or overweight AND 2) to reduce excess body weight and maintain weight reduction long term in adults with obesity, or in adults with overweight in the presence of at least one weight-related comorbid condition.Excluded when used exclusively for weight management in the absence of any of the conditions described above.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sevabertinib - Oral Oncology

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sildenafil - Pulmonary Arterial Hypertension (PAH)

Products Affected

- *sildenafil (pulmonary hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sofosbuvir - Velpatasvir - Voxilaprevir

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	Will not be covered in patients with moderate or severe hepatic impairment (Child-Pugh B or C). Will not be covered for genotypes that are not supported by its FDA approved indication, compendia, or AASLD guidelines.
Required Medical Information	Diagnosis, pertinent lab/diagnostic test results including baseline HCV RNA results and HCV genotype, and documentation of current and previous therapies.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a gastroenterologist, hepatologist, infectious disease specialist, or HCV/HIV specialist.
Coverage Duration	12 to 24 weeks (depending on diagnosis, FDA approved labeling, and AASLD/IDSA guidance).
Other Criteria	Covered for indications recommended in current compendia and AASLD/IDSA guidance. For shared indications, patient must first attempt treatment with Mavyret (glecaprevir/pibrentasvir). For off-label reviews, criteria will be applied consistent with compendia and current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Solriamfetol - Sleep Disorders

Products Affected

- SUNOSI ORAL TABLET 150 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, sleep study results, and documentation of outcome with previous therapies attempted for the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a neurologist or sleep specialist for a diagnosis of cataplexy or excessive daytime sleepiness associated with narcolepsy. Must be prescribed by a neurologist, sleep specialist, or pulmonologist for a diagnosis of Excessive Daytime Sleepiness associated with Obstructive Sleep Apnea.
Coverage Duration	One year
Other Criteria	Sunosi is covered for a diagnosis of excessive daytime sleepiness associated with narcolepsy for adult patients who have had intolerance to or therapeutic failure of both armodafinil and modafinil (armodafinil and modafinil not required in pediatric patients). Sunosi is covered for a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) for patients who have had intolerance to or therapeutic failure of both armodafinil and modafinil. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Somatropin - Growth Hormone

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	When used to increase height, growth hormone therapy will not be covered in pediatric patients with closed epiphyses.
Required Medical Information	General-growth charts, height/weight, height velocity. Somatotropin deficiency in children requires documentation of diminished growth hormone response (max peak less than 10ng/mL) to 2 or more different provocation tests (such as levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon) or documentation of low IGF-1 or IGFBP3 for age, sex, and pubertal status in children age 6 or greater in the absence of chronic disease along with a height velocity less than 25th percentile in the 6-12 months prior to growth hormone therapy. In addition to one of the above findings there must also be documentation of two of the following: 1) growth velocity less than 7cm/yr before age three 2) bone age at least 2 SD below normal for chronological age 3) a known risk factor for growth hormone deficiency (such as congenital hypopituitarism, panhypopituitarism, or prior brain radiation). Somatotropin deficiency in adults requires documentation of negative response to provocative test with max peak of 5ng/mL along with documentation of clinical symptoms such as increased weight and body fat mass, decreased lean body mass, decreased exercise tolerance, decreased muscle mass and strength, reduced cardiac performance, reduced bone density, poor sleep, impaired sense of well-being or lack of motivation. Alternatively, will accept insulin tolerance test with max peak less than 5ng/mL (unless contraindicated in which case will accept IV arginine in combination with GH-releasing hormone with max peak less than 10ng/mL.) If there is documentation of deficiency of 3 or more pituitary hormones, ITT or arginine tests are not required. Recertification- in children requires the following every 12 months: current growth velocity, growth charts (height and weight), current bone age, puberty status, and radiographic testing to determine if epiphyses are closed at age 14 in girls and age 16 in boys.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an endocrinologist, pediatric endocrinologist, nephrologist, infectious disease specialist, or gastroenterologist.
Coverage Duration	One year

PA Criteria	Criteria Details
Other Criteria	Children-covered for treatment of short stature in Turner Syndrome. Covered for children with height less than 3rd percentile for chronological age with renal insufficiency defined as serum creatinine greater than 3.0 mg/dL or creatinine clearance of 5-75 mL/min per 1.73m3 before renal transplant. Covered for Prader-Willi syndrome with short stature or growth failure. Covered for children with intrauterine growth failure or small for gestational age who do not catch up by 2 years of age. Covered for Noonan Syndrome with short stature (when height is at least 2 SD below normal. Covered for children with SHOX deficiency demonstrated by chromosome analysis and whose epiphyses are not closed. Adults and children- growth hormone therapy is covered for a diagnosis of somatotropin deficiency (see required medical info). Covered for AIDS wasting or cachexia or children with HIV associated failure to thrive defined as a greater than 10% of baseline weight loss or weight less than 90% of ideal body weight and either chronic diarrhea or chronic weakness not otherwise explained. Covered for patients with short bowel syndrome who are experiencing malabsorption, malnutrition, weight loss or dehydration despite specialized nutritional support.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sonidegib - Oral Oncology

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sorafenib - Oral Oncology

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sotatercept - Pulmonary Arterial Hypertension (PAH)

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, Winrevair requires at least 3-month trial with at least two standard of care advanced therapies from two different classes (such as PDE5 inhibitor, ERA, soluble guanylate cyclase stimulator (sGC), prostacyclin receptor agonist, prostacyclin). Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sotorasib - Oral Oncology

Products Affected

- LUMAKRAS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sparsentan

Products Affected

- FILSPARI ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a nephrologist or provider specializing in IgA nephropathy or focal segmental glomerulosclerosis.
Coverage Duration	One year.
Other Criteria	Covered to reduce proteinuria in patients with a diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed on biopsy. Patient must have proteinuria (defined as greater than or equal to 0.5 g/day OR a urine protein creatinine ratio (UPCR) greater than or equal to 1.5 g/g). In addition, the patient must have received the maximally tolerated dose of an angiotensin-converting enzyme inhibitor (ACEi) or an angiotensin II receptor blocker (ARB) for a minimum of 3 months prior to starting Filspari, unless the patient is unable to tolerate or has a contraindication to an ACEi or ARB. Covered to reduce proteinuria in patients with focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome confirmed either by biopsy or genetic mutation in podocyte protein associated with FSGS. Recertification will require documentation of stable kidney function attributed to use of approved drug. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sunitinib - Oral Oncology

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Suzetrigine

Products Affected

- JOURNAVX

PA Criteria	Criteria Details
Exclusion Criteria	Will not be covered for treatment of chronic pain (defined as pain lasting one month duration or greater).
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	14 days
Other Criteria	Covered for patients with a diagnosis of moderate to severe acute pain. Acute pain is classified as pain less than one month duration and is usually sudden, time-limited, and caused by injury, trauma, or treatments such as surgery. Subsequent reviews must be for a new moderate to severe acute pain or injury. Repeat treatment for the same injury or acute pain condition will not be authorized. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tadalafil - Pulmonary Arterial Hypertension (PAH)

Products Affected

- *tadalafil (pulmonary hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tadalafil - Tadalafil For Daily Use

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg (generic for cialis)*

PA Criteria	Criteria Details
Exclusion Criteria	Tadalafil for daily use is excluded for the independent diagnosis of Erectile Dysfunction.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Covered for a diagnosis of benign prostatic hyperplasia (BPH).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tafamidis - Vyndamax

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent lab/diagnostic tests, including tests confirming presence of TTR amyloid in cardiac tissue such as 99m Technetium-labeled pyrophosphate cardiac imaging test results (nuclear scintigraphy) positive for TTR amyloid or genetic testing/next-generation sequencing confirming a variant TTR genotype and/or TTR precursor protein.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a specialist experienced in the diagnosis of Transthyretin-mediated Amyloidosis (ATTR-CM), such as a cardiologist.
Coverage Duration	One year.
Other Criteria	Covered for patients with a diagnosis of cardiomyopathy of wild-type (wtATTR-CM) or Hereditary Transthyretin-mediated Amyloidosis (hATTR-CM). Must present clinical evidence of NYHA class I-III heart failure. Evidence of cardiac involvement seen on echocardiography and/or cardiac magnetic imaging, such as thickened left ventricle wall or septum, must be provided. Presence of TTR amyloid in cardiac tissue must be confirmed via 99m Technetium-labeled pyrophosphate cardiac imaging test results (nuclear scintigraphy) positive for TTR amyloid or via genetic testing/next-generation sequencing confirming a variant TTR genotype and/or TTR precursor protein correlated with amyloid deposits identified on cardiac biopsy. Upon recertification, there must be documentation that the patient continues to obtain clinical benefit from the therapy. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Talazoparib - Oral Oncology

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Taletrectinib - Oral Oncology

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tasimelteon - Sleep

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, including supporting lab/diagnostic test results (such as urinary melatonin and/or cortisol levels or actigraphy over a several week interval). For Smith-Magenis Syndrome (SMS), appropriate genetic testing is also required.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a sleep specialist or neurologist.
Coverage Duration	One year
Other Criteria	Covered for a diagnosis of non-24-hour sleep-wake disorder for blind individuals who lack light perception. Based on the patient population used in clinical studies evaluating the efficacy of tasimelteon capsules will only be approved in patients with non-24 who are totally blind. Covered for nighttime sleep disturbances in Smith-Magenis syndrome (SMS). For SMS, patients must provide genetic testing confirmation of chromosome 17p11.2 deletion or RAI1 gene mutation. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tavaborole - Onychomycosis

Products Affected

- *tavaborole*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis, KOH stain or culture results showing presence of trichophyton rubrum or trichophyton mentagrophytes, and documentation of previous therapies
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for the treatment of onychomycosis of the toenails in patients with documented culture or KOH stain positive for Trichophyton rubrum or Trichophyton mentagrophytes. Additionally, unless contraindicated, documentation of failure or severe intolerance to a course of oral terbinafine must be provided. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tazarotene - Topical Retinoids

Products Affected

- ARAZLO
- *tazarotene*
- TRILITAS

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for cosmetic purposes
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Approved for the diagnosis of acne vulgaris and for the diagnosis of plaque psoriasis. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tedizolid

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Documentation of diagnosis, pertinent lab/diagnostic test results (such as bacterial cultures or antibiotic sensitivity testing), and documentation of previous therapies
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None (see Other Criteria)
Coverage Duration	6 days.
Other Criteria	Sivextro is covered when prescribed or recommended by an Infectious Disease specialist. When prescribed by any other prescriber, laboratory data including culture site, organism identified and susceptibility must accompany prior-authorization request and documentation must support the trial. In addition, documentation of therapeutic failure of at least one first-line antibacterial agent that is clinically appropriate for the organism identified must be submitted. Approval will be for 6 days of therapy. Requests for non-FDA approved durations of therapy will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Teduglutide

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis and evidence of dependency on parenteral nutrition support.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Telotristat Ethyl

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	For the treatment of carcinoid syndrome diarrhea, coverage will not be provided in the absence of concurrent somastatin analog therapy (lanreotide or octreotide).
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist, hematologist, endocrinologist, or gastroenterologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of carcinoid syndrome diarrhea with documentation of continued diarrhea despite a minimum 3-month trial of somastatin analog therapy (lanreotide or octreotide). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tepotinib - Oral Oncology

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Teriparatide - Osteoporosis

Products Affected

- *teriparatide 560 mcg/2.24 ml pen*
- *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, DEXA scan report(s), previous therapies
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	Two years (refer to other criteria section).
Other Criteria	Patient must fall into one of the following categories: postmenopausal woman, primary or hypogonadal osteoporosis in a male or patient at risk for steroid induced osteoporosis. Patient must also be at high risk for a fracture defined as 1) history of previous osteoporosis-related fracture, 2) T-score of -2.5 SD or less, 3) T-score between -1.0 and -2.5 SD below normal and a FRAX score for hip fracture of 3% or greater or the risk for other bone fracture is 20% or greater. Patient must also have experienced therapeutic failure, severe intolerance or a contraindication to an oral bisphosphonate or be an inappropriate candidate for oral bisphosphonate therapy based on clinical presentation. Therapeutic failure is defined as a decrease in bone mineral density or a fracture while on bisphosphonate therapy. Severe intolerance defined as chest pain, difficulty swallowing, intense abdominal pain, or chronic dyspepsia when oral bisphosphonate therapy was taken according to manufacturer recommendations. Oral bisphosphonates may be clinically inappropriate for a patient that is bed-ridden/unable to sit upright for 30 minutes unsupervised or has esophageal ulcerations, esophageal stricture, Barrett's esophagitis, or active ulcers. In patients without a trial of or contraindication to oral bisphosphonates, a trial with an injectable bisphosphonate will be accepted in lieu of oral, but is not required. Use of teriparatide for more than 2 years during a patient's lifetime should only be considered if a patient remains at or has returned to having a high risk for fracture. Requests for continued therapy beyond 2 years will require provider attestation that the patient has remained at or has returned to having a high risk for fracture. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Thalidomide

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tiotropium - Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None.
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) in patients who have had an inadequate response or contraindication to both Incruse Ellipta and Spiriva Handihaler. Covered for a diagnosis of MODERATE TO SEVERE ASTHMA as add-on maintenance therapy. Patient must have had drug failure (inadequate or poor asthma symptom control) with at least 3 months of optimal maintenance therapy. Maintenance therapy is defined as an inhaled steroid in combination with a long-acting beta agonist (ICS-LABA) or ICS in combination with a leukotriene inhibitor or theophylline. Recertification for asthma requires documentation of continued use of ICS-LABA (or other maintenance therapy) and clinical benefit from Spiriva Respimat use (such as reduced asthma exacerbations, less use of rescue inhaler). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tipiracil/Trifluridine - Oral Oncology

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tivozanib - Oral Oncology

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tocilizumab - Actemra Biosims

Products Affected

- TYENNE AUTOINJECTOR
- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	Covered for all FDA approved and medically accepted indications with documented inadequate response to ONE preferred product (such as Hadlima, Simlandi, or Rinvoq). Trialed preferred product must share the FDA or medically accepted indication for which current drug is being requested. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tofacitinib

Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	Covered for ANKYLOSING SPONDYLITIS (AS) in pts who have had serious side effects or drug failure w/ ONE of: Hadlima or Simlandi. TNF-blocker-experienced pts must have had serious side effects or drug failure with any AS-indicated TNF-blocker. Covered for POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS in pts who have had inadequate response or intolerance to methotrexate (MTX) or another disease-modifying anti-rheumatic drug (DMARD) and documented failure w/ ONE of: Hadlima or Simlandi. Covered for PSORIATIC ARTHRITIS (PsA) in patients aged 2 and up. Adult patients also must have had serious side effects or drug failure with ONE of: Hadlima or Simlandi. TNF-blocker-experienced pts must have had serious side effects or drug failure with any PsA-indicated TNF-blocker. Covered for active moderate to severe RHEUMATOID ARTHRITIS (RA) in pts who have failed to respond to or are intolerant of ONE of: Hadlima or Simlandi. TNF-blocker-experienced patients must have had serious side effects or drug failure with any RA-indicated TNF-blocker. Covered for moderately to severely active ULCERATIVE COLITIS (UC) in patients who have had inadequate response or intolerance with at least ONE TNF-blocker. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Tolvaptan - Jynarque

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet 15 mg, 30 mg*
- *tolvaptan (polycys kidney dis) oral tablets, sequential 15 mg (am)/ 15 mg (pm), 30 mg (am)/ 15 mg (pm), 45 mg (am)/ 15 mg (pm), 60 mg (am)/ 30 mg (pm), 90 mg (am)/ 30 mg (pm)*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a nephrologist
Coverage Duration	One year
Other Criteria	Covered for the diagnosis of autosomal dominant polycystic kidney disease (ADPKD). ADPKD must be rapidly progressing, as defined by either 1) confirmed GFR decline of at least 3 ml/min/1.73 m2 per year over 1 year and/or 2.5 ml/min/1.73 m2 per year over a period of 5 years or 2) total kidney volume increase of at least 5% per year confirmed by repeated ultrasound or MRI measurements taken at least 6 months apart. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tolvaptan - Samsca

Products Affected

- *tolvaptan oral tablet 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tovorafenib - Oral Oncology

Products Affected

- OJEMDA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trametinib - BRAF/MEK

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Treprostinil - Pulmonary Arterial Hypertension (PAH)

Products Affected

- ORENITRAM
- ORENITRAM MONTH 1 TITRATION KT
- ORENITRAM MONTH 2 TITRATION KT
- ORENITRAM MONTH 3 TITRATION KT
- YUTREPIA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis, right heart catheterization results if PAH
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist
Coverage Duration	One year
Other Criteria	Required for all drugs for pulmonary arterial hypertension (PAH) indication: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest. Additionally, coverage of Orenitram and Yutrepia for PAH require trial with a generic formulary phosphodiesterase-5 enzyme inhibitor (PDE5i) (sildenafil, tadalafil) AND a generic formulary endothelin receptor antagonist (ERA) (ambrisentan, bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Treprostinil - Tyvaso Nebulized Inhalation

Products Affected

- TYVASO
- TYVASO INSTITUTIONAL START KIT
- TYVASO REFILL KIT
- TYVASO STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. For PAH and PAH-ILD: right heart catheterization showing a mean artery pressure of greater than or equal to 25 mmHg at rest, pulmonary capillary wedge pressure less than or equal to 15 mmHg at rest and Pulmonary Vascular Resistance (PVR) greater than 2 wood units (WU). For PAH-ILD, also require baseline PFT results confirming moderate to severely impaired lung disease including FVC less than 70%, AND high-resolution CT scan finding characteristic airway and/or parenchymal abnormalities associated with interstitial lung disease AND baseline 6-minute walk test to assess disease severity and clinical response to treatment, AND baseline NT-proBNP [N-terminal proB-type natriuretic peptide] level.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a pulmonologist or cardiologist.
Coverage Duration	One year.
Other Criteria	For PULMONARY ARTERIAL HYPERTENSION (PAH): coverage of Tyvaso inhalation solution requires a trial with a generic formulary phosphodiesterase-5 enzyme inhibitor (PDE5i) (sildenafil, tadalafil) AND a generic formulary endothelin receptor antagonist (ERA) (ambrisentan, bosentan). Recertification requires objective and/or subjective clinical evidence of disease improvement attributed to use of approved drug(s). Also covered for the treatment of PULMONARY HYPERTENSION ASSOCIATED WITH INTERSTITIAL LUNG DISEASE (WHO Group 3) to improve exercise ability. Must have clinical symptoms associated with PH-ILD such as shortness of breath with exertion that is not fully explained by the severity of lung disease, decreased exercise capacity, labored breathing, fatigue, lethargy. Recertification will require documentation of stabilization or improvement in 6MWT from baseline, decrease in NT-proBNP levels as well as stabilization or reduction in disease severity such as improvements in FVC, reduction in exacerbations of the underling lung disease and clinical worsening. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Nebulized products will also be evaluated for part B versus part D coverage.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tretinoin - Topical Retinoids

Products Affected

- ALTRENO
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	Excluded when used for cosmetic purposes
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Approved for the diagnosis of acne vulgaris. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trientine

Products Affected

- CUVRIOR

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for patients with a diagnosis of stable Wilson's disease who are de-coppered and tolerant to penicillamine. Must have contraindication to penicillamine tablets (generic for Depen) and contraindication to trientine capsules (generic for Syprine). Recertification requires evidence of provider re-evaluation showing that patient cannot be transitioned to maintenance on penicillamine tablets (generic for Depen) or trientine capsules (generic for Syprine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Triheptanoin

Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, via appropriate molecular genetic testing confirming at least one known LC-FAOD mutation such as CPT1A, CPT2, ACADVL, HADHA, or HADHB. If molecular genetic testing is not definitive, then biochemical analysis showing diminished enzyme activity measured on skin fibroblasts must be provided. In addition to one of the above, plasma or dried blood spot acylcarnitine analysis showing a characteristic pattern consistent with LC-FAOD must be provided.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a metabolic disease specialist knowledgeable in disease-related dietary management.
Coverage Duration	One year.
Other Criteria	Covered for patients with molecularly confirmed long-chain fatty acid oxidation disorders. The use of any other medium-chain-triglyceride (MCT) product should be discontinued before starting Dojolvi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Triptorelin - Gonadotropin Releasing Hormone Analogs

Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	Trelstar is covered for palliative treatment of advanced prostate cancer. Requests will also be evaluated for off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Trospium/Xanomeline - Behavioral Health

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year
Other Criteria	For SCHIZOPHRENIA, coverage of Cobenfy requires documentation of a contraindication, inadequate response, or intolerance to Vraylar and at least ONE other generic first-line treatment (such as lurasidone, lithium, valproate, aripiprazole, risperidone, olanzapine, ziprasidone, quetiapine). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tucatinib - Oral Oncology

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Upadacitinib

Products Affected

- RINVOQ LQ
- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.

PA Criteria	Criteria Details
Other Criteria	Covered for ANKYLOSING SPONDYLITIS (AS) in pts who have had serious side effects or drug failure w/ ONE of: Hadlima or Simlandi. TNF-blocker-experienced pts must have had serious side effects or drug failure with any AS-indicated TNF-blocker. Covered for moderate to severe ATOPIC DERMATITIS (AD) involving at least 10% body surface area (BSA). In addition, pt must have received treatment with TWO of the following treatment options during the six months preceding the request: 1) treatment with high-potency topical steroid for minimum 14-day duration or treatment with medium potency topical steroid for minimum 28-day duration, 2) treatment w/ topical tacrolimus, 3) treatment w/ an oral or injectable immunosuppressant, such as a steroid indicated or compendia-supported for treatment of AD, 4) treatment with systemic therapy indicated or compendia-supported for treatment of AD. Covered for moderate to severe CROHN'S DISEASE (CD) in patients who meet ONE of the following conditions: (1) Previous TNF-blocker use: a) the patient has experienced intolerable adverse effects or inadequate response to Hadlima or Simlandi, OR b) patient has trialed another TNF-blocker indicated for CD and experienced intolerable adverse effects or inadequate response OR (2) if TNF-blocker therapy is contraindicated or clinically inappropriate, the patient must have received at least one approved systemic therapy for CD prior to initiating this medication. Covered for a diagnosis of GIANT CELL ARTERITIS. Covered for the diagnosis of NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS. Covered for PSORIATIC ARTHRITIS (PsA) in pts who have had serious side effects or drug failure with ONE of: Hadlima or Simlandi. TNF-blocker-experienced pts must have had serious side effects or drug failure with any PSA-indicated TNF-blocker. Covered for active moderate to severe RHEUMATOID ARTHRITIS (RA) in pts who have failed to respond to or are intolerant of ONE of: Hadlima or Simlandi. TNF-blocker-experienced patients must have had serious side effects or drug failure with any RA-indicated TNF-blocker. Covered for moderately to severely active ULCERATIVE COLITIS (UC) in patients who have had inadequate response or intolerance with at least ONE TNF-blocker. If TNF-blocker therapy is contraindicated or clinically inappropriate, the patient must have received at least one approved systemic therapy for UC. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ursodeoxycholate

Products Affected

- *ursodiol oral capsule 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	None
Coverage Duration	One year.
Other Criteria	Covered for the treatment of radiolucent, non-calcified gallstones in patients for whom elective cholecystectomy is medically inappropriate, as attested by provider. Covered for the prevention of gallstones in obese patients experiencing rapid weight loss. For all indications, documentation of contraindication to generic ursodiol 300 mg capsules and generic ursodiol tablets is required before the approval of ursodiol 200 mg and 400 mg capsules. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ustekinumab - Stelara Biosims

Products Affected

- SELARSDI SUBCUTANEOUS SOLUTION MG/0.5 ML, 90 MG/ML
- SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML
- YESINTEK SUBCUTANEOUS SOLUTION
- YESINTEK SUBCUTANEOUS SYRINGE 45

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an appropriate specialist to treat the stated diagnosis.
Coverage Duration	One year.
Other Criteria	For Selarsdi and Yesintek: Covered for a diagnosis of moderate to severe active CROHN'S DISEASE. Covered for patients with a diagnosis of moderate to severe chronic PLAQUE PSORIASIS that involves at least 3% body surface area. Covered for the diagnosis of moderate to severe chronic PLAQUE PSORIASIS in patients with less than 3% BSA if the affected area involves the hands, feet, facial, scalp or genital regions. Patients also must meet ONE of the following criteria: 1) had a 3-month trial of acitretin, methotrexate, or cyclosporine therapy resulting in intolerance or clinical failure OR 2) have tried UVB/coal tar or Psoralen Ultraviolet A (PUVA) Phototherapy for at least 3 months OR 3) have tried and failed (a) treatment with medium and/or high potency topical corticosteroids for at least 1 month AND (b) ONE of these for at least 3 months: anthralin, calcipotriene, or tazarotene. Covered for the diagnosis of PSORIATIC ARTHRITIS. Covered for the diagnosis of moderately to severely active ULCERATIVE COLITIS. For Stelara & ustekinumab (unbranded Stelara): covered for patients who have a contraindication or inability to use one of the preferred biosimilars, Selarsdi or Yesintek. DOSING: For patients with a diagnosis of psoriasis weighing less than or equal to 100kg, 45mg dose will be approved. For patients with a diagnosis of psoriasis weighing greater than 100kg, 90mg dose will be approved. For patients with a diagnosis of psoriatic arthritis, 45mg dose will be approved. Initial dosing for psoriasis and psoriatic arthritis is at weeks 0, 4, 12 and then every 12 weeks thereafter. For patients with coexistent psoriatic arthritis and moderate to severe plaque psoriasis and who weigh more than 100kg, a 90mg starting dose will be authorized. Initial dosing is at weeks 0, 4, 12 and then every 12 weeks thereafter. For patients with Crohn's disease, weight-dependent induction dosing at week zero and the maintenance dose of 90mg every 8 weeks thereafter will be authorized.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vandetanib - Oral Oncology

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vedolizumab

Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by or in consultation with a Gastroenterologist.
Coverage Duration	One year.
Other Criteria	Covered for the treatment of moderately to severely active Crohn's Disease in patients with a documented failure of two American Gastroenterological Association (AGA) higher efficacy agents: Hadlima, Rinvoq, Selarsdi, Simlandi, Skyrizi, Yesintek. Covered for the treatment of moderately to severely active Ulcerative Colitis in patients who have failed to have an adequate response to or had an intolerance to two AGA higher efficacy agents such as Rinvoq and Skyrizi. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vemurafenib - BRAF/MEK

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Venetoclax - Oral Oncology

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vepdegestrant

Products Affected

- VEPPANU ORAL TABLET 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an oncologist or hematologist.
Coverage Duration	One year.
Other Criteria	Covered for patients that has all 3: (1) a diagnosis of estrogen receptor-positive (ER+) human epidermal growth factor receptor 2-negative (HER2-), ESR1 mutated recurrent unresectable or metastatic breast cancer (mBC) AND (2) has progressed following standard first-line therapy with at least one line of endocrine therapy and a CDK 4/6 inhibitor in the metastatic setting AND (3) hasn't progressed on treatment with another selective estrogen receptor degrader (SERD).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vericiguat

Products Affected

- VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, pertinent diagnostic test results such as but not limited to: echocardiograph results, ECG, chest X-ray, cardiac MRI, or labs (such as BNP or NT-proBNP) to support the heart failure diagnosis. Current and previous therapies used for the treatment of the stated diagnosis.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a Cardiologist
Coverage Duration	One year.
Other Criteria	Covered for a diagnosis of symptomatic chronic heart failure with ejection fraction less than 45% in patients following a hospitalization for heart failure (within past 6 months) or need for outpatient IV diuretics (within past 3 months). Patient must also be stable on standard of care HF treatment (ARNI/ACE-I/ARB plus BB). Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vimseltinib - Oral Oncology

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vismodegib - Oral Oncology

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voclosporin

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis, kidney biopsy results, baseline urine protein/creatinine ratio (UPCR) at time of request, baseline eGFR at time of request, current and previous therapies used for the treatment of the stated diagnosis
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by a rheumatologist or nephrologist
Coverage Duration	Initial approval - 6 months. Recertifications - 1 year.
Other Criteria	Covered for patients with a diagnosis of class III, IV, or V lupus nephritis (LN) confirmed by kidney biopsy. Patient must be established and continue on standard therapy with mycophenolate/MMF and corticosteroids. Lupkynis is not approved for use as monotherapy or with cyclophosphamide-based immunosuppressive therapy. Also, patient must have had previous trial and failure or severe intolerance with Benlysta/belimumab, used either for systemic lupus erythematosus (SLE) or LN. Recertification after initial 6-month approval requires reduction in UPCR from baseline and increase in eGFR from baseline. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Vorasidenib - Oral Oncology

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voriconazole - Voriconazole (IV)

Products Affected

- *voriconazole intravenous recon soln*
- *voriconazole-hpbcd*

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling and excluded for any non-FDA approved or non-medically accepted use, including, but not limited to, preparations such as foot baths, nasal rinses, and mouthwashes.
Required Medical Information	Diagnosis, culture results showing presence of susceptible fungal elements.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	Must be prescribed by an infectious disease specialist or other prescriber specializing in the organ system affected by fungal infection.
Coverage Duration	Initial - 3 mos. Recert: 3 mos if specialist attestation of need for prolonged duration of therapy.
Other Criteria	Covered for FDA approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vorinostat - Oral Oncology

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zanubrutinib - BTKi

Products Affected

- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis and previous therapies used for requested condition, if any
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. For shared indication CLL/SLL, approval of Brukinsa/zanubrutinib requires intolerance or contraindication to Calquence/acalabrutinib AND Imbruvica/ibrutinib. For shared indication MANTLE CELL LYMPHOMA, approval of Brukinsa/zanubrutinib requires intolerance or contraindication to Calquence/acalabrutinib. For share indication WALDENSTROM'S MACROGLOBULINEMIA, approval of Brukinsa/zanubrutinib requires intolerance or contraindication to Imbruvica/ibrutinib. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Zidesamtinib - oral oncology

Products Affected

- JIDEYTRO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ziftomenib - Oral Oncology

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling.
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zongertinib - Oral Oncology

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	As limited by FDA labeling
Required Medical Information	Diagnosis supported by diagnostic tests and/or laboratory results in accordance with NCCN guidelines. Documentation includes both current and prior therapies administered for the specified condition.
Age Restrictions	Patient age must be consistent with the FDA approval for the stated diagnosis.
Prescriber Restrictions	For cancer diagnosis, must be prescribed by an oncologist or hematologist, or urologist in the case of prostate cancer. For non-cancer diagnosis, must be prescribed by an appropriate specialist.
Coverage Duration	One year
Other Criteria	Covered for FDA-approved indications. Requests for non-FDA approved indications will be evaluated according to the Medicare statutory off-label use requirements. Renewal criteria: documentation that disease progression has not occurred.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INDEX OF DRUGS