Network Health Insurance Corporation

Network Health Select (PPO)

Network Health Choice (PPO)

Network Health PlusRx (PPO)

Network Health PremierRx (PPO)

Network Health Go (PPO)

Network Health Anywhere (PPO)

Prior Authorization Criteria

Last Updated 10/2026

ABIRATERONE - EVICORE

MEDICATION(S)
ABIRATERONE ACETATE 250 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABIRTEGA - EVICORE

MEDICATION(S)
ABIRTEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACETYLCYSTEINE - PART D VS PART B

MEDICATION(S)

ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL

DETAILS

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

ACTEMRA

MEDICATION(S)

TYENNE 162 MG/0.9 ML SYRINGE, TYENNE AUTOINJECTOR

PENDING CMS APPROVAL

ACTIMMUNE - EVICORE

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACYCLOVIR - PART D VS PART B

MEDICATION(S)

ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL

DETAILS

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

ADEMPAS

MEDICATION(S)

ADEMPAS

PENDING CMS APPROVAL

AGENTS FOR GAUCHER DISEASE

MEDICATION(S)
MIGLUSTAT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, genetic tests and lab results

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a geneticist, endocrinologist, hepatologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.

COVERAGE DURATION
1 year

OTHER CRITERIA
Gaucher Disease, Type 1-approve if there is demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts OR molecular genetic testing documenting glucocerebrosidase gene mutation.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AGENTS FOR UREA CYCLE DISORDERS

MEDICATION(S)

SODIUM PHENYLBUTYRATE

PENDING CMS APPROVAL

AIMOVIG

MEDICATION(S)
AIMOVIG AUTOINJECTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Combination with a CGRP antagonist when the CGRP antagonist is being used for prophylaxis

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
For Initial approval: The member must have a diagnosis of Chronic migraine or Episodic migraine.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AKEEGA - EVICORE

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALBUTEROL - PART D VS PART B

MEDICATION(S)

ALBUTEROL 100 MG/20 ML SOLN, ALBUTEROL 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 25 MG/5 ML SOLUTION, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL 75 MG/15 ML SOLN, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN

DETAILS

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

ALECENSA - EVICORE

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALOSETRON

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclude if patient is biologically male

REQUIRED MEDICAL INFORMATION
Diagnosis, Reauth: positive clinical response

AGE RESTRICTION
18 years and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months, continuation: 1 year

OTHER CRITERIA
Severe diarrhea-predominant Irritable bowel syndrome (IBS): 1.Initial: Approve if the patient meets the following (a, b, c and d):
a. Patient has experienced chronic IBS symptoms for 6 months or longer, b. Patient had anatomic or biochemical abnormalities of the gastrointestinal track excluded, c. Patient has tried and failed one anti-diarrheal agent (e.g. loperamide), d. Patient has tried and failed one antispasmodic agent (e.g. dicyclomine). 2. Continuation: Approve if the patient meets the following (a, b and c):
a. If patient is new to plan, meets initial criteria at time they had started the medication, b. Documented dose and frequency are within the FDA approved dosing and frequency, c. Patient is experiencing a positive clinical response to therapy

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

ALPHA 1 PROTEINASE INHIBITORS

MEDICATION(S)
ARALAST NP, GLASSIA, PROLASTIN C 1,000 MG/20 ML VL, ZEMAIRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Alpha1-Antitrypsin (AAT) Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)- approve if the patient meets both of the following (a and b):
a) Patient has a baseline (pretreatment) AAT serum concentration of less than 11 micromol/L [less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry].
b) Patient is a current non-smoker

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ALUNBRIG - EVICORE

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMBRISENTAN

MEDICATION(S)

AMBRISENTAN

PENDING CMS APPROVAL

AMPHOTERICIN B - PART D VS PART B

MEDICATION(S)

AMPHOTERICIN B 50 MG VIAL, AMPHOTERICIN B LIPOSOME

DETAILS

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

ANTICONVULSANT - BRIVARACETAM

MEDICATION(S)

BRIVARACETAM 100 MG TABLET, BRIVARACETAM 10 MG/ML ORAL SOL, BRIVARACETAM 10 MG TABLET, BRIVARACETAM 25 MG TABLET, BRIVARACETAM 50 MG TABLET, BRIVARACETAM 75 MG TABLET

PENDING CMS APPROVAL

ANTICONVULSANT - DIACOMIT

MEDICATION(S)

DIACOMIT

PENDING CMS APPROVAL

ANTICONVULSANT - DILANTIN

MEDICATION(S)

DILANTIN 30 MG CAPSULE

PENDING CMS APPROVAL

ANTICONVULSANT - ESLICARBAZEPINE

MEDICATION(S)

ESLICARBAZEPINE ACETATE

PENDING CMS APPROVAL

ANTICONVULSANT - FELBAMATE

MEDICATION(S)

FELBAMATE

PENDING CMS APPROVAL

ANTICONVULSANT - METHSUXIMIDE

MEDICATION(S)

METHSUXIMIDE

PENDING CMS APPROVAL

ANTICONVULSANT - PERAMPANEL

MEDICATION(S)

PERAMPANEL

PENDING CMS APPROVAL

ANTICONVULSANT - RUFINAMIDE

MEDICATION(S)

RUFINAMIDE

PENDING CMS APPROVAL

ANTICONVULSANT - SPRITAM

MEDICATION(S)

SPRITAM

PENDING CMS APPROVAL

ANTICONVULSANT - SUBVENITE

MEDICATION(S)

SUBVENITE 10 MG/ML SUSPENSION

PENDING CMS APPROVAL

ANTICONVULSANT - SYMPAZAN

MEDICATION(S)

SYMPAZAN

PENDING CMS APPROVAL

ANTICONVULSANT - TIAGABINE

MEDICATION(S)

TIAGABINE HCL

PENDING CMS APPROVAL

ANTICONVULSANT - TOPIRAMATE

MEDICATION(S)

TOPIRAMATE 25 MG/ML SOLUTION

PENDING CMS APPROVAL

ANTICONVULSANT - VIGABATRIN

MEDICATION(S)

VIGABATRIN, VIGADRONE, VIGAFYDE

PENDING CMS APPROVAL

ANTICONVULSANT - XCOPRI

MEDICATION(S)

XCOPRI

PENDING CMS APPROVAL

ANTICONVULSANT - ZONISADE

MEDICATION(S)

ZONISADE

PENDING CMS APPROVAL

ANTIFUNGALS (IV)

MEDICATION(S)
VORICONAZOLE 200 MG/20 ML VIAL, VORICONAZOLE 200 MG VIAL, VORICONAZOLE (HPBCD)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

APREPITANT - PART D VS PART B

MEDICATION(S)

APREPITANT

DETAILS

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

ARANESP

MEDICATION(S)

ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL

PENDING CMS APPROVAL

ARFORMOTEROL - PART D VS PART B

MEDICATION(S)

ARFORMOTEROL TARTRATE

DETAILS

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

ARIKAYCE

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, Amikacin MIC

AGE RESTRICTION
MAC-18 years and older

PRESCRIBER RESTRICTION
MAC-prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections.

COVERAGE DURATION
1 year

OTHER CRITERIA
MAC Lung disease: Initial-approve if the patient has NOT achieved negative sputum cultures for MAC since completion of most recent background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen AND the MAC isolate is susceptible to amikacin with minimum inhibitor concentration (MIC) of less than or equal to 64 microgram/mL. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Continuation: Patient has not achieved negative sputum cultures for MAC OR patient has achieved negative sputum cultures for MAC for less than 12 months.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ARMODAFINIL

MEDICATION(S)

ARMODAFINIL

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - ASENAPINE

MEDICATION(S)

ASENAPINE MALEATE, SECUADO

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - BYSANTI

MEDICATION(S)
BYSANTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
When the non-preferred product is requested, documentation must be provided including the preferred medication tried, dates of preferred drug trial, and/or the specific reason for requesting the exception (for example, the reason for failure on the preferred product, the contraindication to the preferred product, the adverse reaction experience with the preferred product, or the clinical condition for which an exception to the preferred product is requested.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 years

OTHER CRITERIA
The drug must be prescribed within the manufacturer’s published dosing guidelines or the dose falls within dosing guidelines found in accepted compendia or current literature AND one of the following: The member has demonstrated a failure of or intolerance Lybalvi and Vraylar OR the member has a documented contraindication to Lybalvi and Vraylar OR the member has had an adverse reaction or would be reasonably expected to have an adverse reaction to Lybalvi and Vraylar OR the member has a clinical condition for which there is no listed preferred formulary alternative to treat the condition based on published guidelines or clinical literature.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

ATYPICAL ANTIPSYCHOTICS - CAPLYTA

MEDICATION(S)

CAPLYTA

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - CLOZAPINE

MEDICATION(S)

CLOZAPINE ODT, VERSACLOZ

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - FANAPT

MEDICATION(S)

FANAPT

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - OLANZAPINE-FLUOXETINE

MEDICATION(S)

OLANZAPINE-FLUOXETINE HCL

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - OPIPZA

MEDICATION(S)

OPIPZA

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - PALIPERIDONE ER

MEDICATION(S)

PALIPERIDONE ER

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - QUETIAPINE ER

MEDICATION(S)

QUETIAPINE FUMARATE ER

PENDING CMS APPROVAL

ATYPICAL ANTIPSYCHOTICS - REXULTI

MEDICATION(S)

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

PENDING CMS APPROVAL

AUGTYRO - EVICORE

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AUSTEDO

MEDICATION(S)

AUSTEDO, AUSTEDO XR, AUSTEDO XR TITR(12-18-24-30MG)

PENDING CMS APPROVAL

AVMAPKI FAKZYNJA - EVICORE

MEDICATION(S)
AVMAPKI-FAKZYNJA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AYVAKIT - EVICORE

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZACITIDINE - EVICORE

MEDICATION(S)
AZACITIDINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZATHIOPRINE - PART D VS PART B

MEDICATION(S)

AZATHIOPRINE 50 MG TABLET

DETAILS

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

BALVERSA - EVICORE

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BASAL INSULIN - INSULIN GLARGINE

MEDICATION(S)

BASAGLAR KWIKPEN U-100, INSULIN GLARGINE MAX SOLOSTAR, INSULIN GLARGINE SOLOSTAR U300, REZVOGLAR KWIKPEN

PENDING CMS APPROVAL

BASAL INSULIN - TRESIBA

MEDICATION(S)
TRESIBA, TRESIBA FLEXTOUCH U-100, TRESIBA FLEXTOUCH U-200

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Previous therapies

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
The member must meet one of the following criteria (A), (B), (C), OR (D): (A) The member has demonstrated a failure to one of the preferred products, Lantus, insulin glargine-YFGN or Toujeo, for the given diagnosis, (B) The member has demonstrated an intolerance to one of the preferred products, (C) The member has a documented contraindication to one of the preferred products, or (D) The member had an adverse reaction or would be reasonably expected to have an adverse reaction to one of the preferred products for the requested indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

BENLYSTA

MEDICATION(S)

BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE

PENDING CMS APPROVAL

BESREMI - EVICORE

MEDICATION(S)
BESREMI, BESREMI PEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BEXAROTENE - EVICORE

MEDICATION(S)
BEXAROTENE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSENTAN

MEDICATION(S)

BOSENTAN 125 MG TABLET, BOSENTAN 62.5 MG TABLET

PENDING CMS APPROVAL

BOSULIF - EVICORE

MEDICATION(S)
BOSULIF 100 MG CAPSULE, BOSULIF 100 MG TABLET, BOSULIF 500 MG TABLET, BOSULIF 50 MG CAPSULE, BOSUTINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BRAFTOVI - EVICORE

MEDICATION(S)
BRAFTOVI 75 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BRUKINSA

MEDICATION(S)
BRUKINSA 160 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Mantle Cell Lymphoma, Chronic Lymphocytic Lymphoma, Small Lymphocytic Lymphoma – Approve if patient meets one of the following:
1.The patient has demonstrated an intolerance to the preferred products, Calquence.
2.The patient has a documented contraindication to Calquence.
3.The patient had an adverse reaction or would be reasonably expected to have an adverse reaction to Calquence.
4.The patient has a clinical condition for which there is no listed preferred formulary alternatives to treat the condition based on published guidelines or clinical literature.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

BUDESONIDE - PART D VS PART B

MEDICATION(S)

BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP

DETAILS

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

CABOMETYX - EVICORE

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CALQUENCE - EVICORE

MEDICATION(S)
CALQUENCE 100 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CAPRELSA - EVICORE

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARGLUMIC ACID

MEDICATION(S)

CARGLUMIC ACID

PENDING CMS APPROVAL

CAYSTON

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of cystic fibrosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Member has Pseudomonas aeruginosa colonization in the lungs and has recurrence despite prior use of tobramycin inhalation solution or tobramycin resistance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CIALIS

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Erectile Dysfunction. Concomitant use of nitrates.

REQUIRED MEDICAL INFORMATION
The member must have a diagnosis of benign prostatic hyperplasia.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial duration 6 months. If BPH symptoms improve (AUA-SI score decrease), approve for lifetime

OTHER CRITERIA
The daily dose is prescribed as 2.5 mg or 5 mg once daily. The member must have symptoms of at least moderate severity that are bothersome, as defined by the American Urological Association Symptom Index (AUA-SI) greater than or equal to 8. Must have tried and failed or be intolerant of or contraindicated to two other drugs, one each from any two of the following different therapeutic classes: Alpha-1 adrenergic blockers (terazosin, doxazosin, tamsulosin, alfuzosin, silodosin) tried for a minimum of one month at the maximum tolerated dose, 5-alpha reductase inhibitors (finasteride, dutasteride) tried for a minimum of four months at the maximum tolerated dose, combination alpha-1 adrenergic blocker/5-alpha reductase inhibitors (dutasteride/tamsulosin) tried for a minimum of four months at the maximum tolerated dose.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

CINACALCET - PART D VS PART B

MEDICATION(S)

CINACALCET HCL

DETAILS

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

CLINIMIX E - PART D VS PART B

MEDICATION(S)

CLINIMIX E 2.75%-5% SOLUTION, CLINIMIX E 4.25%-10% SOLUTION, CLINIMIX E 4.25%-5% SOLUTION, CLINIMIX E 5%-15% SOLUTION, CLINIMIX E 5%-20% SOLUTION

DETAILS

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

CLINIMIX - PART D VS PART B

MEDICATION(S)

CLINIMIX 4.25%-10% SOLUTION, CLINIMIX 4.25%-5% SOLUTION, CLINIMIX 5%-15% SOLUTION, CLINIMIX 5%-20% SOLUTION

DETAILS

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

COBENFY

MEDICATION(S)

COBENFY, COBENFY STARTER PACK

PENDING CMS APPROVAL

COMETRIQ - EVICORE

MEDICATION(S)
COMETRIQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COPIKTRA - EVICORE

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COSENTYX

MEDICATION(S)

COSENTYX (2 SYRINGES), COSENTYX SENSOREADY (2 PENS), COSENTYX SENSOREADY PEN, COSENTYX SYRINGE, COSENTYX UNOREADY PEN

PENDING CMS APPROVAL

COTELLIC - EVICORE

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CRESEMBA

MEDICATION(S)

CRESEMBA 186 MG CAPSULE, CRESEMBA 74.5 MG CAPSULE

PENDING CMS APPROVAL

CRINONE GEL

MEDICATION(S)
CRINONE 8% GEL

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

OFF LABEL USES
Support of an established pregnancy.

EXCLUSION CRITERIA
Use in patients to supplement or replace progesterone in the management of infertility.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Secondary amenorrhea, 12 months. Support of an established pregnancy, 9 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CROMOLYN - PART D VS PART B

MEDICATION(S)

CROMOLYN 20 MG/2 ML NEB SOLN

DETAILS

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

CYCLOPHOSPHAMIDE - PART D VS PART B

MEDICATION(S)

CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG TABLET

DETAILS

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

CYCLOSPORINE - PART D VS PART B

MEDICATION(S)

CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, GENGRAF 100 MG CAPSULE, GENGRAF 25 MG CAPSULE

DETAILS

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

DALFAMPRIDINE

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The member has sustained walking impairment AND the member is able to walk.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or MS specialist.

COVERAGE DURATION
Initial: 1 year. Continuation: 3 years

OTHER CRITERIA
For continuation, authorization will be granted to members with multiple sclerosis for improvement in walking if the member has experienced an improvement in walking speed OR another objective measure of walking ability since starting dalfampridine.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DANZITEN - EVICORE

MEDICATION(S)
DANZITEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DASATINIB - EVICORE

MEDICATION(S)
DASATINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DAURISMO - EVICORE

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DECNUPAZ - EVICORE

MEDICATION(S)
DECNUPAZ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEFERASIROX

MEDICATION(S)
DEFERASIROX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, ferritin levels

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist or oncologist

COVERAGE DURATION
1 year

OTHER CRITERIA
1.For Chronic iron overload due to blood transfusions: Ferritin level consistently greater than 1000 mcg/L
2.For chronic overload in non-transfusion dependent thalassemia syndromes (member meets both a and b): a. Patient has liver iron concentration levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of deferasirox AND b. Patient has serum ferritin levels consistently greater than 300 mcg/L prior to initiation of treatment

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

DEFERIPRONE

MEDICATION(S)
DEFERIPRONE, DEFERIPRONE (3 TIMES A DAY)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Transfusional iron overload in patients with myelodysplastic syndrome or in patients with Diamond Blackfan anemia.

REQUIRED MEDICAL INFORMATION
Diagnosis, ANC

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist or oncologist

COVERAGE DURATION
1 year

OTHER CRITERIA
Member meets all of the following (1, 2 and 3): 1. Diagnosis of transfusional iron overload due to one of the following a. Thalassemia syndromes, b. Sickle cell disease, c. Transfusional-dependent anemia AND 2. Absolute neutrophil count (ANC) is greater than 1.5 x 10^9/L AND 3. Has tried and failed, has intolerance or contraindication to one chelation therapy (e.g. generic deferasirox).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DIABETIC SUPPLIES

MEDICATION(S)

1ST TIER UNIFINE PENTIPS, 1ST TIER UNIFINE PENTIPS PLUS, ADVOCATE PEN NEEDLE, ADVOCATE PEN NEEDLES 5MM 31G, ADVOCATE PEN NEEDLES 8MM 31G, ADVOCATE INS 0.3 ML 30GX5/16", ADVOCATE INS 0.3 ML 31GX5/16", ADVOCATE INS 0.5 ML 30GX5/16", ADVOCATE INS 0.5 ML 31GX5/16", ADVOCATE INS 1 ML 31GX5/16", ADVOCATE INS SYR 1 ML 30GX5/16, AIMSCO MINI ULTRA-THIN II, ALCOHOL PREP PADS, ALCOHOL SWABS, ASSURE ID DUO PRO SFTY PEN NDL, ASSURE ID PEN NEEDLE 30GX5/16", AUTOSHIELD DUO PEN NEEDLE, BAND-AID GAUZE PADS 2"X2", CAREFINE PEN NEEDLE, CARETOUCH INSULIN SYRINGE, CARETOUCH PEN NEEDLE, CLICKFINE, COMFORT EZ 0.3 ML 31G 15/64", COMFORT EZ 0.5 ML 31G 15/64", COMFORT EZ INS 0.3ML 30GX1/2", COMFORT EZ INS 0.3ML 30GX5/16", COMFORT EZ INS 0.5ML 31GX5/16", COMFORT EZ INS 1 ML 31G 15/64", COMFORT EZ INS 1 ML 31GX5/16", COMFORT EZ INSULIN SYR 0.3 ML, COMFORT EZ INSULIN SYR 0.5 ML, COMFORT EZ SYR 0.3 ML 29GX1/2", COMFORT EZ SYR 0.5 ML 28GX1/2", COMFORT EZ SYR 0.5 ML 29GX1/2", COMFORT EZ SYR 0.5 ML 30GX1/2", COMFORT EZ SYR 1 ML 28GX1/2", COMFORT EZ SYR 1 ML 29GX1/2", COMFORT EZ SYR 1 ML 30GX1/2", COMFORT EZ SYR 1 ML 30GX5/16", COMFORT EZ PEN NEEDLE, COMFORT TOUCH PEN NEEDLE, CURITY GAUZE PADS, DROPLET INSULIN SYRINGE, DROPLET MICRON PEN NEEDLE, DROPLET PEN NEEDLE, DROPSAFE PEN NEEDLE 31G 5MM, DROPSAFE PEN NEEDLE 31G 8MM, DROPSAFE PEN NEEDLE 31GX1/4", EASY COMFORT 0.5 ML 30GX1/2", EASY COMFORT 0.5 ML 31GX5/16", EASY COMFORT 0.5 ML 32GX5/16", EASY COMFORT 1 ML 31GX5/16", EASY COMFORT 1 ML 32GX5/16", EASY COMFORT SYR 0.5ML 29G 8MM, EASY COMFORT SYR 1 ML 29G 8MM, EASY COMFORT SYR 1 ML 30GX1/2", EASY COMFORT PEN NDL 29G 4MM, EASY COMFORT PEN NDL 29G 5MM, EASY COMFORT PEN NDL 31GX3/16", EASY COMFORT PEN NDL 31GX5/16", EASY COMFORT PEN NDL 33G 4MM, EASY COMFORT PEN NDL 33G 5MM, EASY COMFORT PEN NDL 33G 6MM, EASY COMFORT PEN NEEDLES, EASY COMFORT SAFETY PEN NEEDLE, EASY GLIDE INSULIN SYRINGE, EASY GLIDE PEN NEEDLE, EASY TOUCH INSULIN SYR 1 ML, EASY TOUCH FLIPLOCK INSULIN, EASY TOUCH INS 1 ML 27G 12.7MM, EASY TOUCH INS 1 ML 28G 12.7MM, EASY TOUCH INS 1 ML 29G 12.7MM, EASY TOUCH SYR 0.5ML 27G12.7MM, EASY TOUCH SYR 0.5ML 28G12.7MM, EASY TOUCH SYR 0.5ML 29G12.7MM, EASY TOUCH SYR 1 ML 27G 16MM, EASY-TOUCH INSULIN SYRINGE, EASY TOUCH PEN NEEDLE, EASY TOUCH SAFETY PEN NEEDLE, EASY TOUCH SHEATHLOCK INSULIN, EMBRACE PEN NEEDLE, FREESTYLE PRECISION, CVS COTTON GAUZE 2"X2", STERILE GAUZE PADS 2"X 2", CVS GAUZE PADS 2"X2", GAUZE PAD, STERILE 2"X2", GNP STERILE GAUZE PADS 2" X 2", CVS GAUZE PAD 2"X2" STERILE, CVS GAUZE PADS 2" X 2", EQL GAUZE PADS 2"X2", GAUZE PADS 2" X 2 " STERILE, GAUZE PADS NON-STERILE 2X2, GAUZE PADS STERILE 2X2, GAUZE PADS & DRESSINGS -

PADS 2 X 2, HEALTHWISE INSULIN SYRINGE, HEALTHWISE PEN NEEDLE, HEALTHY ACCENTS PENTIP 5MM 31G, HEALTHY ACCENTS PENTIP 6MM 31G, HEALTHY ACCENTS PENTIP 8MM 31G, HM INSULIN SYRINGE, INCONTROL PEN NEEDLE, COMFORT POINT PEN NDL 29GX1/2", COMFORT POINT PEN NDL 31GX1/4", COMFORT POINT PEN NDL 31GX1/6", INSULIN PEN NEEDLE, AIMSCO INS SYR 0.3 ML 29GX1/2", AIMSCO INS SYR 0.3 ML 30GX5/16, AIMSCO INS SYR 0.5 ML 29GX1/2", AIMSCO INS SYR 1 ML 29GX1/2", AIMSCO INS SYR 1 ML 30GX5/16", AIMSCO INSULIN 0.3 ML SYRINGE, AIMSCO INSULIN 0.3 ML SYRNGE, AIMSCO INSULIN 0.5 ML SYRINGE, AIMSCO INSULIN 0.5 ML SYRNGE, AIMSCO INSULIN 1 ML SYRINGE, AIMSCO SYRING 0.3 ML 31GX5/16", AIMSCO SYRING 0.5 ML 30GX5/16", AIMSCO SYRING 0.5 ML 31GX5/16", B-D INSULIN U100-1 ML SYRNG, B-D INSULIN U100-1 ML SYRNGE, B-D INSULIN U40-1 ML SYRINGE, BL INSULIN 0.3 ML SYRINGE, BL INSULIN 0.5 ML SYRINGE, BL INSULIN 1 ML SYRINGE, BL INSULIN SYRINGE 0.3 ML, BL INSULIN SYRINGE 0.5 ML, BL INSULIN SYRINGE 1 ML, BROOKS INSULIN 0.3 ML SYRN, BROOKS INSULIN 1/2 ML SYRN, BROOKS INSULIN SYRINGE 1 ML, CA INS SYR 0.3 ML 30GX5/16", CA INS SYR 0.3 ML 31GX5/16", CA INS SYR 0.5 ML 30GX5/16", CA INS SYR 0.5 ML 31GX5/16", CA INSULIN SYR 0.3 ML 29GX1/2", CA INSULIN SYR 0.5 ML 29GX1/2", CA INSULIN SYR 1 ML 29GX1/2", CA INSULIN SYR 1 ML 30GX5/16", CA INSULIN SYR 1 ML 31GX5/16", CAREONE INS SYR 1 ML 30GX5/16", CAREONE SYR 0.3 ML 30GX1/2", CAREONE SYR 0.3 ML 31GX5/16", CAREONE SYR 0.5 ML 30GX1/2", CAREONE SYR 0.5 ML 31GX5/16", CAREONE SYR 1 ML 30GX1/2", CAREONE SYR 1 ML 31GX5/16", CVS INSULIN SYR 1 ML 29GX1/2", CVS SYRINGE 1/2 ML, CVS SYRINGE 3/10 ML, DG INSULIN SYR 29G-3/10 ML, DG INSULIN SYRINGE 28G-0.5 ML, DG INSULIN SYRINGE 28G-1 ML, DG INSULIN SYRINGE 29G-0.5 ML, D&K INSULIN SYRINGE 0.3 ML, D&K INSULIN SYRINGE 0.5 ML, D&K INSULIN SYRINGE 1 ML, ECK INSULIN 1/2 ML SYRINGE, ECK INSULIN 1 ML SYRINGE, ECK INSULIN 3/10 ML SRYINGE, ECK INSULIN 3/10 ML SYRINGE, EQL INS SYR 0.3 ML 29GX1/2", EQL INS SYR 0.3 ML 30GX5/16", EQL INS SYR 0.5 ML 29GX1/2", EQL INS SYR 0.5 ML 30GX5/16", EQL INSULIN SYR 1 ML 29GX1/2", EQL INSULIN SYR 1 ML 30GX5/16", EQL INSULIN SYR 1 ML 31GX5/16", EQL INSUL SYR 0.3 ML 31GX5/16", EQL INSUL SYR 0.5 ML 31GX5/16", EXEL INS SYR U100 1 ML 28GX1/2, EXEL INSUL SYR 0.5 ML 28GX1/2", FIFTY50 INS 0.3 ML 31GX5/16", FIFTY50 INS 0.5 ML 31GX5/16", FIFTY50 INS SYR 1 ML 31GX5/16", FIRST CHOICE SYRINGE 0.3 ML, FIRST CHOICE SYRINGE 0.5 ML, FIRST CHOICE SYRINGE 1 ML, FP INSULIN 0.3 ML SYRINGE, FP INSULIN 0.5 ML SYRINGE, FP INSULIN 1 ML SYRINGE, FP INSULIN SYRINGE 0.3 ML, FP INSULIN SYRINGE 0.5 ML, FP INSULIN SYRINGE 1 ML, GENTLE TOUCH 1 ML SYRINGE, GNP INS SYRINGE 1 ML 28G 1/2", GNP INSUL SYR 0.5 ML 31GX5/16", HCA INSULIN SYRINGE 0.3 ML, HCA INSULIN SYRINGE 0.5 ML, HCA INSULIN SYRINGE 1 ML, HM INSULIN SYRINGE 0.3 ML, HM INSULIN SYRINGE 0.5 ML, HM INSULIN SYRINGE 1 ML, HY-VEE INS SYRINGE 0.5 ML, HY-VEE INS SYRINGE 1 ML, HY-VEE INS SYRINGE 3/10 ML, INS SYR U100 0.5 ML 29GX1/2", INSULIN 1/2 ML SYRINGE, INSULIN 1 ML SYRINGE, INSULIN 3/10 ML SYRINGE, INSULIN SYR 0.3ML

31GX1/4(1/2), INSULIN SYR 0.5 ML 28G 12.7MM, INSULIN SYR 1 ML HARD PACK, INSULIN SYRIN 0.3 ML 29GX1/2", INSULIN SYRIN 0.3 ML 30GX1/2", INSULIN SYRIN 0.3 ML 30GX5/16", INSULIN SYRIN 0.3 ML 31GX5/16", INSULIN SYRIN 0.5 ML 28GX1/2", INSULIN SYRIN 0.5 ML 29GX1/2", INSULIN SYRIN 0.5 ML 30G 5/16", INSULIN SYRIN 0.5 ML 30GX5/16", INSULIN SYRIN 0.5 ML 31G 5/16", INSULIN SYRIN 0.5 ML 31GX5/16", INSULIN SYRING 0.5 ML 27G 1/2", INSULIN SYRING 0.5 ML 28G 1/2", INSULIN SYRING 0.5 ML 29G 1/2", INSULIN SYRING 0.5 ML 29GX1/2", INSULIN SYRINGE 0.3 ML, INSULIN SYRINGE 0.3 ML 31GX1/4, INSULIN SYRINGE 0.5 ML, INSULIN SYRINGE 0.5 ML 31GX1/4, INSULIN SYRINGE 1/2 ML, INSULIN SYRINGE 1 ML, INSULIN SYRINGE 1 ML 27G 1/2", INSULIN SYRINGE 1 ML 27G 16MM, INSULIN SYRINGE 1 ML 27GX1/2", INSULIN SYRINGE 1 ML 28G 1/2", INSULIN SYRINGE 1ML 28G 12.7MM, INSULIN SYRINGE 1 ML 28GX1/2", INSULIN SYRINGE 1 ML 29G 1/2", INSULIN SYRINGE 1 ML 29GX1/2", INSULIN SYRINGE 1 ML 30G 1/2", INSULIN SYRINGE 1 ML 30GX1/2", INSULIN SYRINGE 1 ML 30GX5/16", INSULIN SYRINGE 1 ML 31G 5/16", INSULIN SYRINGE 1 ML 31GX1/4", INSULIN SYRINGE 1 ML 31GX5/16", INSULIN SYRINGE 28GX0.5 ML, INSULIN SYRINGE 28GX1 ML, INSULIN SYRINGE 29G-0.3 ML, INSULIN SYRINGE 29G-0.5 ML, INSULIN SYRINGE 3/10 ML, INSULIN SYRINGE U-100, INSULIN SYRINGE U100 0.5 ML, INSULIN SYRINGE U100 1/2 ML, INSULIN SYRINGE U100 1 ML, KMART VALU PLUS SYR 3/10 ML, KMART VALU PLUS SYRINGE 1 ML, KROGER 0.5 ML INSULIN SYRINGE, KROGER 1 ML INSULIN SYRINGE, KROGER INS SYR 1 ML 29GX1/2", KROGER INS SYRINGE 0.5 ML, KROGER INS SYRINGE 3/10 ML, KROGER INSULIN SYRINGE 0.3M, KROGER INSULIN SYRINGE 0.3 ML, KRO INS SYRIN 0.3 ML 30GX5/16", KRO INS SYRIN 0.3 ML 31GX5/16", KRO INS SYRIN 0.5 ML 30GX5/16", KRO INS SYRIN 0.5 ML 31GX5/16", KRO INS SYRING 0.5 ML 29GX1/2", KRO INS SYRINGE 1 ML 29GX1/2", KRO INS SYRINGE 1 ML 30GX5/16", KRO INS SYRINGE 1 ML 31GX5/16", LEADER INS SYR 0.3 ML 29GX1/2", LEADER INS SYR 0.5 ML, LEADER INS SYR 0.5 ML 28GX1/2", LEADER INS SYR 0.5 ML 29GX1/2", LEADER INS SYR 0.5 ML 30GX1/2", LEADER INS SYR 1 ML, LEADER INS SYR 1 ML 28GX1/2", LEADER INS SYR 1 ML 29GX1/2", LEADER INS SYR 1 ML 30GX1/2", LEADER INS SYR 1 ML 31GX5/16", LEADER INS SYR 3/10 ML, LEADER INSULIN SYRINGE 0.3 ML, LEADER INSULIN SYRINGE 0.5 ML, LEADER INSULIN SYRINGE 1 ML, LEADER SYRING 0.3 ML 31GX5/16", LEADER SYRING 0.5 ML 31GX5/16", LONGS INS SYR 0.5 ML 29GX1/2", LONGS INS SYR 1 ML 29GX1/2", LONGS INSULIN SYRINGE 0.3 ML, LONGS INSULIN SYRINGE 0.5 ML, LONGS INSULIN SYRINGE 1 ML, MAJOR INSULIN SYRINGE 0.3 ML, MAJOR INSULIN SYRINGE 0.5 ML, MAJOR INSULIN SYRINGE 1 ML, MEDIC DRUG INSULIN SYR 0.3 ML, MS INS SYR 0.5 ML 29GX1/2", MS INS SYR 1 ML 29GX1/2", MS INS SYRINGE 1 ML 30GX1/2", MS INSULIN SYR 0.3 ML 29GX1/2", MS INSULIN SYR 1 ML 31GX5/16", MS INSULIN SYRINGE 0.3 ML, MS INSULIN SYRINGE 0.5 ML, MS INSULIN SYRINGE 1 ML, MS INSULIN SYRINGE 3/10 ML, MS INSUL SYR 0.3 ML 31GX5/16", MS INSUL SYR 0.5 ML 30GX1/2", MS INSUL SYR 0.5 ML 31GX5/16", PV INS SYRIN 1 ML 29GX1/2", PV INSULIN SYR 1 ML 31GX5/16", PV INSULIN SYRINGE 0.5 ML, PV INSUL SYR 0.3 ML 31GX5/16", PV INSUL SYR 0.5

ML 31GX5/16", QC INSULIN SYR 1 ML 31GX5/16", QC INSULIN SYRINGE 0.3 ML, QC INSULIN SYRINGE 0.5 ML, QC INSULIN SYRINGE 1 ML, QC INSUL SYR 0.5 ML 31GX5/16", RELION INS SYR 0.3 ML 31GX6MM, RELION INS SYR 0.5 ML 31GX6MM, RELION INS SYR 1 ML 31GX15/64", RELI-ON INSULIN 0.3 ML SYR, RELI-ON INSULIN 0.5 ML SYR, RELI-ON INSULIN 1 ML SYR, RELION INSULIN SYR 0.3 ML, RELION INSULIN SYR 0.5 ML, RELION INSULIN SYRINGE 1 ML, SB INS SYR 0.5 ML 29GX1/2", SB INS SYR 0.5 ML 30GX5/16", SB INS SYR 1 ML 29GX1/2", SB INS SYRINGE 1 ML 30GX5/16", SB INSULIN SYR 1 ML 31GX5/16", SB INSULIN SYRINGE 0.3 ML, SB INSULIN SYRINGE 0.5 ML, SB INSULIN SYRINGE 1 ML, SB INSULN SYR 0.5 ML 30GX5/16", SCHNUCKS SYR 0.5 ML 29GX1/2", SCHNUCKS SYR 0.5 ML 30GX5/16", SM INS SYR 0.5 ML 29GX1/2", SM INS SYR 0.5 ML 30GX5/16", SM INS SYR 1 ML 29GX1/2", SM INS SYRING 0.3 ML 30GX5/16", SM INS SYRINGE 1 ML 28GX1/2", SM INS SYRINGE 1 ML 30GX5/16", SM INSULIN SYR 0.3 ML 29GX1/2", SM INSULIN SYR 0.5 ML 28GX1/2", SM INSULIN SYR 1 ML 31GX5/16", SM INSUL SYR 0.3 ML 31GX5/16", SM INSUL SYR 0.5 ML 31GX5/16", SUNMARK INSULIN SYRINGE 0.3 ML, SUNMARK INSULIN SYRINGE 0.5 ML, SUNMARK INSULIN SYRINGE 1 ML, VALUEPLUS SYR 0.3 ML 29GX1/2", VH INS SYR 0.5 ML 29GX1/2", VH INS SYR 1 ML 29GX1/2", WDMEDIC INS SYR 1 ML 30GX5/16", WD MEDIC INSULIN SYR 0.3 ML, WD MEDIC INSULIN SYR 0.5 ML, WD MEDIC INSULIN SYRNGE 1 ML, WD MEDIC SYR 0.3 ML 30GX5/16", WD MEDIC SYR 0.5 ML 29GX1/2", WD MEDIC SYR 0.5 ML 30GX5/16", WD MEDIC SYR 1 ML 29GX1/2", WDMEDIC SYRING 0.3 ML 29GX1/2", INSULIN SYRINGE (DISP) U-100 0.3 ML, INSULIN SYRINGE (DISP) U-100 1/2 ML, INSULIN SYRINGE (DISP) U-100 1 ML, INSUPEN 31G ULTRAFIN NEEDLE, INSUPEN 32G 6MM PEN NEEDLE, INSUPEN PEN NEEDLE 32GX5/32", INSUPEN PEN NEEDLE 29GX1/2", INSUPEN PEN NEEDLE 29GX12MM, INSUPEN PEN NEEDLE 31GX3/16", INSUPEN PEN NEEDLE 31GX5/16", INSUPEN PEN NEEDLE 31GX8MM, INSUPEN PEN NEEDLE 32G 6MM, INSUPEN PEN NEEDLE 32GX4MM, INSUPEN PEN NEEDLE 32GX5/32", ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD, MAXICOMFORT II PEN NEEDLE, MAXICOMFORT INSULIN SYRINGE, MAXICOMFORT SAFETY PEN NEEDLE, MICRODOT READYGARD PEN NEEDLE, MINI PEN NEEDLE, MINI ULTRA-THIN II, BL MONOJECT SYRINGE 0.5 ML, BL MONOJECT SYRINGE 1 ML, BL MONOJECT SYRINGE 3/10 ML, GNP MONOJECT SYRINGE 0.5 ML, GNP MONOJECT SYRINGE 1 ML, GNP MONOJECT SYRINGE 3/10 ML, KIN-RAY MONOJECT SYRINGE, KP MONOJECT SYRINGE 0.5 ML, KP MONOJECT SYRINGE 1 ML, KP MONOJECT SYRINGE 3/10 ML, LEADER MONOJECT SYR 0.5 ML, LEADER MONOJECT SYR 1 ML, LEADER MONOJECT SYR 3/10 ML, LEGEND MONOJECT SYRINGE 1 ML, LEGEND MONOJECT SYRNGE 0.3 ML, LEGEND MONOJECT SYRNGE 0.5 ML, MED-FAST MONOJECT SYRINGE, MED SHOPPE MONOJCT SYR 3/10, MED SHOPPE MONOJECT SYR 0.5, MED SHOPPE MONOJECT SYR 1 ML, MONOJECT 0.3 ML INSULIN SYR, MONOJECT 0.3 ML SYRN 29GX1/2", MONOJECT 1 ML SYRN 25X5/8", MONOJECT INSUL SYR U100, MONOJECT INSUL SYR U100 0.5 ML, MONOJECT INSUL SYR U100 1 ML, PHARM MONOJECT SYRINGE 0.5 ML, QC MONOJECT SYRINGE 0.5 ML, QC

MONOJECT SYRINGE 1 ML, QC MONOJECT SYRINGE 3/10 ML, RUGBY MONOJECT SYRINGE 0.5 ML, RUGBY MONOJECT SYRINGE 1 ML, TOPCO MONOJECT SYR 3/10 ML, TOPCO MONOJECT SYRINGE 0.5 ML, TOPCO MONOJECT SYRINGE 1 ML, VALUE HEALTH MONOJECT SYRN, NANO 2 GEN PEN NEEDLE 32G 4MM, NANO PEN NEEDLE, NEEDLES, INSULIN DISP., SAFETY, NOVOFINE PLUS, EQL PEN 8MM 31G X 5/16" NEEDLE, EQL PEN NEEDLE 6MM 31G, FIFTY50 PEN 31G X 3/16" NEEDLE, FIFTY50 PEN 31G X 5/16" NEEDLE, FIFTY50 PEN NEEDLE 32G X 1/4", FIFTY50 PEN NEEDLE 32G X 5/32", GNP CLICKFINE PEN NDL 31GX1/4", GNP CLICKFINE PEN NDL 31GX5/16, GNP PEN NEEDLE 31G 5MM, GNP PEN NEEDLE 31G 8MM, GNP PEN NEEDLE 32G 4MM, GNP PEN NEEDLE 32G 6MM, GS PEN NEEDLE 31G X 1/4", GS PEN NEEDLE 31G X 5/16", GS PEN NEEDLE 31G X 5MM, GS PEN NEEDLE 31G X 6MM, GS PEN NEEDLE 31G X 8MM, GS PEN NEEDLE 32G X 4MM, GS PEN NEEDLE 32G X 6MM, KROGER PEN NEEDLES 31G X 5/16", KRO PEN NEEDLE 4MM X 32G, KRO PEN NEEDLE 4MM X 33G, KRO PEN NEEDLE 5MM X 31G, KRO PEN NEEDLE 6MM X 31G, KRO PEN NEEDLE 8MM X 31G, LEADER PEN NEEDLE 6MM 31G, LIVE BETTER PEN NEEDLE 6MM 31G, LIVE BETTER PEN NEEDLES 12MM, LIVE BETTER PEN NEEDLES 8MM, MS PEN NEEDLE 6MM 31G, PEN NEEDLE 12MM 29G, PEN NEEDLE 29G 12MM, PEN NEEDLE 30G 8MM, PEN NEEDLE 31G 5MM, PEN NEEDLE 31G 6MM, PEN NEEDLE 31G 8MM, PEN NEEDLE 31G X 1/4", PEN NEEDLE 31G X 3/16", PEN NEEDLE 31G X 5/16", PEN NEEDLE 32G 4MM, PEN NEEDLE 32G X 1/4", PEN NEEDLE 32G X 3/16", PEN NEEDLE 32G X 5/32", PEN NEEDLE 33G 4MM, PEN NEEDLE 4MM 32G, PEN NEEDLE 5MM 31G, PEN NEEDLE 6MM 31G, PEN NEEDLES 12MM 29G, PEN NEEDLES 29G, PEN NEEDLES 31G, PEN NEEDLES 8MM 31G, PUB PEN 12MM 29G NEEDLES, PUB PEN 8MM 31G NEEDLES, PUB PEN NEEDLE 6MM 31G, PV PEN NEEDLE 6MM 31G, PV PEN NEEDLES 6MM 31G, PX PEN 12MM 29G NEEDLES, PX PEN 8MM 31G NEEDLES, QC UNIFINE PENTIP 6MM 31G, RA PEN NEEDLE 31GX3/16", RA PEN NEEDLE 31GX5/16", RELION MINI PEN 31G X 1/4" NDL, RELION PEN 29G NEEDLE, RELION PEN 31G NEEDLE, RELION PEN NEEDLE 29GX1/2", RELION PEN NEEDLE 31G 6MM, RELION PEN NEEDLE 31GX1/4", RELION PEN NEEDLE 31GX5/16", RELION PEN NEEDLE 32GX5/32", TODAY'S HLTH PN NEEDLE 6MM 31G, TODAY'S HLTH PN NEEDLE 8MM 31G, TODAY'S HLT PN NEEDLE 12MM 29G, PEN NEEDLES, PENTIPS, PENTIPS PEN NEEDLE, PIP PEN NEEDLE, PREVENT DROPSAFE PEN NEEDLE, PRO COMFORT INSULIN SYRINGE, PRO COMFORT PEN NEEDLE, PRODIGY INS SYR 1ML 28GX1/2", PRODIGY SYRNG 0.5 ML 31GX5/16", PURE COMFORT PEN NEEDLE, RELION ULTRA COMFORT, SAFETYGLIDE INSULIN SYRINGE, SAFETY PEN NEEDLE, SECURESAFE PEN NDL 30GX5/16", FP STERILE PAD 2" X 2", BL STERILE PADS 2"X2", ECK STERILE PADS 2"X2", FT STERILE PADS 2" X 2", GNP STERILE PADS 2"X2", PV STERILE PADS 2" X 2", QC STERILE PADS 2"X2", RA STERILE PADS, SM STERILE PADS 2" X 2", STERILE PADS 2" X 2", STERILE PADS 2"X2", SURE COMFORT, SURE COMFORT INSULIN SYRINGE, SURE COMFORT PEN NEEDLE, SURE COMFORT SAFETY PEN NEEDLE, SURE-FINE PEN NEEDLES, TECHLITE 0.3 ML 31GX6MM (1/2), TECHLITE 0.3 ML

31GX8MM (1/2), TECHLITE 0.5 ML 30GX12MM (1/2), TECHLITE 0.5 ML 31GX6MM (1/2), TECHLITE 0.5 ML 31GX8MM (1/2), TECHLITE INS SYR 1 ML 30GX12MM, TECHLITE INS SYR 1 ML 31GX6MM, TECHLITE INS SYR 1 ML 31GX8MM, TECHLITE PEN NEEDLE 29GX1/2", TECHLITE PEN NEEDLE 31GX3/16", TECHLITE PEN NEEDLE 31GX5/16", TECHLITE PEN NEEDLE 32GX1/4", TECHLITE PEN NEEDLE 32GX5/32", TECHLITE PLUS PEN NEEDLE, TOPCARE CLICKFINE, TRUE COMFORT INSULIN SYRINGE, TRUE COMFORT PEN NEEDLE, TRUE COMFORT PRO INS SYRINGE, TRUE COMFORT PRO PEN NEEDLE, TRUE COMFORT SAFE INSULIN SYRG, TRUE COMFORT SAFETY PEN NEEDLE, TRUEPLUS PEN NEEDLE, ULTICARE INSULIN SYRINGE, ULTICARE PEN NEEDLE, ULTICARE SAFETY PEN NEEDLE, ULTIGUARD SAFEPACK-INSULIN SYR, ULTIGUARD SAFEPACK 32G 4MM, ULTILET PEN NEEDLE, ULTRACARE INSULIN SYRINGE, ULTRACARE PEN NEEDLE, SM ULT CFT 0.3ML 29GX1/2"(1/2), SM ULT CFT 0.3ML 31GX5/16(1/2), ULTRA COMFORT 0.3 ML SYRINGE, ULTRA COMFORT 0.5 ML 28GX1/2", ULTRA COMFORT 0.5 ML 30GX5/16", ULTRA COMFORT 0.5 ML SYRINGE, ULTRA COMFORT 1/2 ML SYRINGE, ULTRA COMFORT 1 ML SYRINGE, ULTRA COMFORT 3/10 ML SYR, ULTRA COMFORT 3/10 ML SYRNG, ULTRA COMFORT SYRINGE 0.3 ML, ULTRA COMFORT SYRINGE 0.5 ML, ULTRA COMFORT SYRINGE 1 ML, ULTRA-FINE INSULIN SYRINGE, ULTRA-FINE PEN NEEDLE, ULTRA FLO INSULIN SYRINGE, ULTRA FLO PEN NEEDLE, ULTRA THIN PEN NDL 32G X 4MM, ULTRA-THIN II PEN NDL 29GX1/2", ULTRA-THIN II PEN NDL 31GX5/16, UNIFINE OTC PEN NEEDLE, CAREONE UNIFINE PENTIP 4MM 32G, CAREONE UNIFINE PENTIP 5MM 31G, CAREONE UNIFINE PENTIP 6MM 31G, CAREONE UNIFINE PENTIP 8MM 31G, CAREONE UNIFINE PNTP 12MM 29G, DR UNIFINE PENTIPS 12MM NDL, DR UNIFINE PENTIPS 6MM NDL, DR UNIFINE PENTIPS 8MM NDL, PC UNIFINE PENTIPS 12MM NEEDLE, PC UNIFINE PENTIPS 31GX3/16", PC UNIFINE PENTIPS 6MM NEEDLE, PC UNIFINE PENTIPS 8MM NEEDLE, PV UNIFINE PENTIPS 31GX3/16", PV UNIFINE PENTIPS 32GX5/32", QC UNIFINE PENTIPS 32GX5/32", QC UNIFINE PENTIPS 4MM 32G, SHOPKO UNIFINE PENTIPS 4MM 32G, SHOPKO UNIFINE PENTIPS 5MM 31G, SHOPKO UNIFINE PENTIPS 8MM 31G, SHOPKO UNIFINE PNTIPS 12MM 29G, UNIFINE PENTIP 0.5CC NEEDLE, UNIFINE PENTIPS 12MM 29G, UNIFINE PENTIPS 12MM NEEDLE, UNIFINE PENTIPS 31G 5MM, UNIFINE PENTIPS 31G 6MM, UNIFINE PENTIPS 31G 8MM, UNIFINE PENTIPS 31GX3/16", UNIFINE PENTIPS 32G 4MM, UNIFINE PENTIPS 32G 6MM, UNIFINE PENTIPS 32GX1/4", UNIFINE PENTIPS 32GX5/32", UNIFINE PENTIPS 33GX5/32", UNIFINE PENTIPS 6MM 31G, UNIFINE PENTIPS 6MM NEEDLE, UNIFINE PENTIPS 8MM 31G, UNIFINE PENTIPS 8MM NEEDLE, UNIFINE PENTIPS 8MM NEEDLES, UNIFINE PENTIPS MAXFLOW, UNIFINE PENTIPS PLUS, UNIFINE PENTIPS PLUS MAXFLOW, UNIFINE PROTECT, UNIFINE SAFECONTROL PEN NEEDLE, UNIFINE ULTRA PEN NDL 31G 5MM, UNIFINE ULTRA PEN NDL 31G 6MM, UNIFINE ULTRA PEN NDL 31G 8MM, UNIFINE ULTRA PEN NDL 32G 4MM, VANISHPOINT 29GX1/2" 1 ML SR, VANISHPOINT INS 1 ML 30GX3/16", VERIFINE PEN NEEDLE

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 years

OTHER CRITERIA
Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DICHLORPHENAMIDE

MEDICATION(S)
DICHLORPHENAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, prior medication trials, potassium levels

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 2 months, Continuation: 3 years

OTHER CRITERIA
Hypokalemic periodic paralysis (HypoPP) and related variants initial therapy: Members must meet all of the following (1, 2, 3, and 4): 1. HypoPP has been confirmed by one of the following (a, b or c): a. Serum potassium concentration of less than 3.5 mEq/L during a paralytic attack OR b. Family history of the condition OR c. Genetically confirmed skeletal muscle calcium or sodium channel mutation, 2. Member had improvements in paralysis attack symptoms with potassium intake, 3. Member has tried and failed oral acetazolamide therapy, 4. The prescribing physician has excluded other reasons for acquired hypokalemia (e.g. renal, adrenal, thyroid dysfunction, renal tubular acidosis, diuretic and laxative abuse). Hyperkalemia periodic paralysis (HyperPP) and related variants initial therapy: Members must meet all of the following (1, 2, and 3): 1. HyperPP has been confirmed by one of the following (a, b or c) a. Serum potassium concentration during a paralytic attack greater than 4.5 mEq/L OR b. A family history of the condition OR c. Genetically confirmed skeletal muscle sodium channel

mutation 2. Prescribing physician has excluded other reasons for acquired hyperkalemia (e.g. drug abuse, renal and adrenal dysfunction) 3. Member has tried and failed oral acetazolamide therapy. HypoPP, HyperPP and related variants continuation of therapy: Patient has responded to dichlorphenamide (e.g. decrease in the frequency or severity of paralytic attacks) as determined by the prescribing physician.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

DICLOFENAC

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DOXEPIN TOPICAL

MEDICATION(S)
DOXEPIN 5% CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of moderate pruritus. Patient has atopic dermatitis or lichen simplex chronicus.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month

OTHER CRITERIA
The patient had an inadequate response, contraindication, or intolerance to at least one medium potency topical corticosteroid, or is not a candidate for topical corticosteroids (e.g., treatment is on face, axilla, or groin).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DPP-4/SGLT2

MEDICATION(S)

STEGLUJAN

PENDING CMS APPROVAL

DRONABINOL - PART D VS PART B

MEDICATION(S)

DRONABINOL 10 MG CAPSULE, DRONABINOL 2.5 MG CAPSULE, DRONABINOL 5 MG CAPSULE

DETAILS

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

DROXIDOPA

MEDICATION(S)

DROXIDOPA

PENDING CMS APPROVAL

DUPIXENT

MEDICATION(S)

DUPIXENT PEN, DUPIXENT 200 MG/1.14 ML SYRING, DUPIXENT 300 MG/2 ML SYRINGE

PENDING CMS APPROVAL

EBGLYSS

MEDICATION(S)

EBGLYSS PEN, EBGLYSS SYRINGE

PENDING CMS APPROVAL

ELIGARD - EVICORE

MEDICATION(S)
ELIGARD

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EMGALITY

MEDICATION(S)
EMGALITY PEN, EMGALITY SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Combination with a CGRP antagonist when the CGRP antagonist is being used for prophylaxis

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Chronic or episodic migraine: 12 months. Episodic cluster (Emgality): 6 months.

OTHER CRITERIA
For chronic or episodic migraine initiation of therapy: The member must have a diagnosis of migraine.
For episodic cluster headache: approve if the patient has diagnosis of episodic cluster headaches.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENBREL

MEDICATION(S)

ENBREL 25 MG/0.5 ML SYRINGE, ENBREL 25 MG/0.5 ML VIAL, ENBREL 50 MG/ML SYRINGE, ENBREL MINI, ENBREL SURECLICK

PENDING CMS APPROVAL

ENDARI

MEDICATION(S)
L-GLUTAMINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Glutamine will be used to reduce the acute complications of sickle cell disease.

AGE RESTRICTION
The patient is greater than or equal to 5 years of age.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist or oncologist.

COVERAGE DURATION
1 year

OTHER CRITERIA
The patient is currently taking Hydroxyurea or has an intolerance or contraindication to Hydroxyurea therapy.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ENSACOVE - EVICORE

MEDICATION(S)
ENSACOVE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENTYVIO SC

MEDICATION(S)

ENTYVIO PEN

PENDING CMS APPROVAL

EPCLUSA

MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

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

OFF LABEL USES
Indications consistent with current AASLD/IDSA guidance

EXCLUSION CRITERIA
Combination use with other direct acting antivirals, excluding ribavirin

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
3 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.

COVERAGE DURATION
Will be consistent with AASLD/IDSA guidance

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EPIDIOLEX

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
The member is 1 year of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
Lifetime.

OTHER CRITERIA
For seizures associated with Lennox-Gastaut Syndrome, the patient must have a previous trial of ONE of the following: lamotrigine, topiramate, rufinamide, clobazam, valproate, felbamate or clonazepam. For seizures associated with Dravet Syndrome, the patient must have a previous trial of ONE of the following: valproate, clobazam, topiramate, Diacomit or Fintepla. For tuberous sclerosis complex approve if the patient has tried at least one other antiepileptic drug.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ERIVEDGE - EVICORE

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERLEADA - EVICORE

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERLOTINIB - EVICORE

MEDICATION(S)
ERLOTINIB HCL 100 MG TABLET, ERLOTINIB HCL 150 MG TABLET, ERLOTINIB HCL 25 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVDI - EVICORE

MEDICATION(S)
EVDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVEKEO

MEDICATION(S)
AMPHETAMINE SULFATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Weight loss.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EVEROLIMUS - EVICORE

MEDICATION(S)

EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, YULITHIRA

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

EVEROLIMUS - PART D VS PART B

MEDICATION(S)

EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, EVEROLIMUS 1 MG TABLET

DETAILS

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

EVICORE ONCOLOGY DRUGS

MEDICATION(S)

ADCETRIS, ADSTILADRIN, ALYMSYS, ANKTIVA, ARSENIC TRIOXIDE, ARZERRA, ASPARLAS, AVASTIN 100 MG/4 ML VIAL, AVASTIN 400 MG/16 ML VIAL, BAVENCIO, BCG (TICE STRAIN), BEIZRAY 80 MG/4 ML VIAL, BEIZRAY-ALBUMIN, BELEODAQ, BENDAMUSTINE HCL, BESPONSA, BIZENGRI, BLENREP 70 MG VIAL, BLEOMYCIN SULFATE, BLINCYTO, BORTEZOMIB 1 MG VIAL, BORTEZOMIB 2.5 MG VIAL, BORTEZOMIB 3.5 MG/1.4 ML VIAL, BORTEZOMIB 3.5 MG IV VIAL, BORTEZOMIB 3.5 MG VIAL, CARBOPLATIN, CARMUSTINE 100 MG VIAL, CARMUSTINE 300 MG VIAL, CISPLATIN 100 MG/100 ML VIAL, CISPLATIN 200 MG/200 ML VIAL, CISPLATIN 50 MG/50 ML VIAL, CISPLATIN 50 MG VIAL, CLADRIBINE 10 MG/10 ML VIAL, CLOFARABINE, COLUMVI, CYCLOPHOSPHAMIDE 1 GM/5 ML VL, CYCLOPHOSPHAMIDE 1 GM VIAL, CYCLOPHOSPHAMIDE 2 GM/10 ML VL, CYCLOPHOSPHAMIDE 2 GM VIAL, CYCLOPHOSPHAMIDE 500 MG/2.5 ML, CYCLOPHOSPHAMIDE 500 MG VIAL, CYRAMZA, CYTARABINE, DACARBAZINE, DACTINOMYCIN, DANYELZA, DARZALEX, DARZALEX FASPRO, DATROWAY, DAUNORUBICIN HCL, DECITABINE, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, ELAHERE, ELREXFIO, ELZONRIS, EMPLICITI, EMRELIS, ENHERTU, EPIRUBICIN HCL, EPKINLY, ERBITUX, ERIBULIN MESYLATE, ETOPOSIDE 1,000 MG/50 ML VIAL, ETOPOSIDE 100 MG/5 ML VIAL, ETOPOSIDE 500 MG/25 ML VIAL, FLOXURIDINE, FLUDARABINE PHOSPHATE, FLUOROURACIL 1 GRAM/20 ML VIAL, FLUOROURACIL 2.5 GRAM/50 ML VL, FLUOROURACIL 500 MG/10 ML VIAL, FLUOROURACIL 5 GRAM/100 ML VL, FRINDOVYX, FULVESTRANT, FYARRO, GEMCITABINE HCL, HERCEPTIN, HERCEPTIN HYLECTA, HERCESSI, HERZUMA, IDARUBICIN HCL, IFOSFAMIDE, IMDELLTRA, IMFINZI, IMJUDO, INLEXZO, IRINOTECAN HCL, IXEMPRA, JEMPERLI, JEVTANA, JOBEVNE, KADCYLA, KANJINTI, KEYTRUDA, KEYTRUDA QLEX, KIMMTRAK, KOMZIFTI, KYPROLIS, LEUCOVORIN CAL 100 MG/10 ML VL, LEUCOVORIN CAL 500 MG/50 ML VL, LEUCOVORIN CALCIUM 100 MG VIAL, LEUCOVORIN CALCIUM 200 MG VIAL, LEUCOVORIN CALCIUM 350 MG VIAL, LEUCOVORIN CALCIUM 500 MG VIAL, LEUCOVORIN CALCIUM 50 MG VIAL, LEVOLEUCOVORIN 175 MG/17.5 ML, LEVOLEUCOVORIN 250 MG/25 ML VL, LIBTAYO, LOQTORZI, LUNSUMIO, LUNSUMIO VELO, LYNOZYFIC, MARGENZA, MELPHALAN HCL, MITOMYCIN 20 MG VIAL, MITOMYCIN 40 MG VIAL, MITOMYCIN 5 MG VIAL, MITOXANTRONE HCL, MONJUVI, MVASI, MYLOTARG, NELARABINE, NIPENT, OGIVRI, ONCASPAR, ONIVYDE, ONTRUZANT, OPDIVO, OPDIVO QVANTIG, OPDUALAG, OXALIPLATIN, PACLITAXEL, PACLITAXEL PROTEIN-BOUND, PADCEV, PEMETREXED 100 MG/4 ML VIAL, PEMETREXED 1 GM/40 ML VIAL, PEMETREXED 500 MG/20 ML VIAL, PEMETREXED DISODIUM, PERJETA, PHESGO, POLIVY, POTELIGEO, PRALATREXATE, PROLEUKIN, RIABNI, RITUXAN, RITUXAN HYCELA, ROMIDEPSIN, RUXIENCE, RYBREVANT, RYBREVANT FASPRO, RYLAZE, RYTELO, SARCLISA, SYLVANT, TALVEY, TECENTRIQ, TECENTRIQ HYBREZA,

TECVAYLI, TEMODAR, TEMSIROLIMUS, TEPADINA 200 MG BAG, TEVIMBRA, THIOTEPA 100 MG VIAL, THIOTEPA 15 MG VIAL, TIVDAK, TOPOTECAN HCL 4 MG/4 ML VIAL, TOPOTECAN HCL 4 MG VIAL, TRAZIMERA, TRODELVY, TRUXIMA, UNITUXIN, VALRUBICIN, VECTIBIX, VEGZELMA, VINBLASTINE SULFATE, VINORELBINE TARTRATE, VYLOY, VYXEOS, YERVOY, YONDELIS, ZALTRAP, ZEPZELCA, ZIIHERA, ZIRABEV, ZOLADEX, ZYNLONTA, ZYNYZ

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

EXXUA

MEDICATION(S)

EXXUA

PENDING CMS APPROVAL

FARXIGA

MEDICATION(S)

FARXIGA

PENDING CMS APPROVAL

FASENRA

MEDICATION(S)

FASENRA, FASENRA PEN

PENDING CMS APPROVAL

FAVLYXA - EVICORE

MEDICATION(S)
FAVLYXA 250 MG/10 ML VIAL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
1 year

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FILGRASTIM

MEDICATION(S)
ZARXIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Severe chronic neutropenia: 6 mo. AIDS: 4 mo. Aplastic or agranulocytosis: 1 mo. All others: 1 year.

OTHER CRITERIA
1.Severe Chronic Neutropenia - Member must have a diagnosis of congenital, cyclic or idiopathic neutropenia
2.Neutropenia associated with acquired immunodeficiency syndrome - Member has diagnosis of AIDS with neutropenia
3.Aplastic anemia – approve
4.Agranulocytosis - Member must have diagnosis of congenital or drug-induced agranulocytosis
5.Hematopoietic Syndrome of Acute Radiation Syndrome – approve
6.Patients with cancer receiving myelosuppressive chemotherapy – approve
7.Patients with acute myeloid leukemia receiving induction or consolidation chemotherapy – approve
8.Patients with cancer undergoing bone marrow transplantation – approve
9.Patients undergoing autologous peripheral blood progenitor cell collection and therapy - approve

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

FILSPARI

MEDICATION(S)

FILSPARI

PENDING CMS APPROVAL

FINTEPLA

MEDICATION(S)

FINTEPLA

PENDING CMS APPROVAL

FIRAZYR

MEDICATION(S)

ICATIBANT, SAJAZIR

PENDING CMS APPROVAL

FIRMAGON - EVICORE

MEDICATION(S)
FIRMAGON

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FORMOTEROL - PART D VS PART B

MEDICATION(S)

FORMOTEROL 20 MCG/2 ML NEB VL

DETAILS

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

FOTIVDA - EVICORE

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FRUZAQLA - EVICORE

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GAVRETO - EVICORE

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GEFITINIB - EVICORE

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GILOTRIF - EVICORE

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GIP/GLP-1 AGONIST

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other GLP-1 or GIP/GLP-1 agonists (e.g. Ozempic, Rybelsus, Trulicity, Victoza)

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
For Type 2 diabetes mellitus (T2DM), member must have diagnosis of T2DM

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLP-1 OZEMPIC

MEDICATION(S)
OZEMPIC 0.25-0.5 MG/DOSE PEN, OZEMPIC 1.5 MG TABLET, OZEMPIC 1 MG/DOSE (4 MG/3 ML), OZEMPIC 2 MG/DOSE (8 MG/3 ML), OZEMPIC 4 MG TABLET, OZEMPIC 9 MG TABLET, RYBELSUS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other GLP-1 or GIP/GLP-1 agonists (e.g. Ozempic, Rybelsus, Wegovy, Trulicity, Victoza, Mounjaro, Zepbound)

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
For Type 2 diabetes mellitus (T2DM), member must have a diagnosis of type 2 diabetes mellitus

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLP-1 TRULICITY

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other GLP-1 or GIP/GLP-1 agonists (e.g. Ozempic, Rybelsus, Wegovy, Victoza, Mounjaro, Zepbound)

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
For Type 2 diabetes mellitus (T2DM), member must have a diagnosis of type 2 diabetes mellitus

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GOMEKLI - EVICORE

MEDICATION(S)
GOMEKLI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GRANISETRON - PART D VS PART B

MEDICATION(S)

GRANISETRON HCL 1 MG TABLET

DETAILS

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

GRANIX - EVICORE

MEDICATION(S)
GRANIX 300 MCG/0.5 ML SAFE SYR, GRANIX 300 MCG/0.5 ML SYRINGE, GRANIX 300 MCG/ML VIAL, GRANIX 480 MCG/0.8 ML SAFE SYR, GRANIX 480 MCG/0.8 ML SYRINGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GROWTH HORMONE

MEDICATION(S)

GENOTROPIN

PENDING CMS APPROVAL

HAEGARDA

MEDICATION(S)

HAEGARDA

PENDING CMS APPROVAL

HARVONI

MEDICATION(S)
HARVONI 33.75-150 MG PELLET PK, HARVONI 45-200 MG PELLET PACKT, HARVONI 45-200 MG TABLET, LEDIPASVIR-SOFOSBUVIR

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

OFF LABEL USES
Indications consistent with current AASLD/IDSA guidance

EXCLUSION CRITERIA
Combination use with other direct acting antivirals, excluding ribavirin.

REQUIRED MEDICAL INFORMATION
Hep C genotype, cirrhosis status.

AGE RESTRICTION
3 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with GI, hepatologist, ID, or liver transplant MD.

COVERAGE DURATION
12 weeks or 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HEP B VACCINE - PART D VS PART B

MEDICATION(S)

ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, HEPLISAV-B, RECOMBIVAX HB

DETAILS

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

HERNEXEOS - EVICORE

MEDICATION(S)
HERNEXEOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HETLIOZ

MEDICATION(S)

TASIMELTEON

PENDING CMS APPROVAL

HIGH RISK MEDICATION - FIRST GENERATION ANTIHISTAMINES

MEDICATION(S)
PROMETHAZINE 12.5 MG/10 ML CUP, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 6.25 MG/5 ML CUP, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP

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

OFF LABEL USES
Nausea and vomiting associated with chemotherapy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be for 12 months.

OTHER CRITERIA
Unless specifically referenced, all other FDA approved indications not excluded from Part D will be covered as first line therapy without other previous drug trial criteria requirements. For anti-emetic use, approve promethazine hydrochloride tablets or syrup if the patient has either tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, aprepitant) for the current condition OR approve if the member requires promethazine use secondary to cancer/chemotherapy related emesis. Prior to approval of any drug, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that the physician would still like to initiate/continue therapy.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

HUMIRA

MEDICATION(S)

HADLIMA, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HADLIMA PUSHTOUCH, SIMLANDI(CF) 20 MG/0.2 ML SYRG, SIMLANDI(CF) 40 MG/0.4 ML SYRG, SIMLANDI(CF) AUTOINJECTOR

PENDING CMS APPROVAL

HYFTOR

MEDICATION(S)

HYFTOR

PENDING CMS APPROVAL

HYRNUO - EVICORE

MEDICATION(S)
HYRNUO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IBRANCE - EVICORE

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IBTROZI - EVICORE

MEDICATION(S)
IBTROZI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ICLUSIG - EVICORE

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IDHIFA - EVICORE

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IDIOPATHIC PULMONARY FIBROSIS - NINTEDANIB

MEDICATION(S)

NINTEDANIB ESYLATE, OFEV

PENDING CMS APPROVAL

IDIOPATHIC PULMONARY FIBROSIS - PIRFENIDONE

MEDICATION(S)

PIRFENIDONE

PENDING CMS APPROVAL

IMATINIB

MEDICATION(S)
IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB, IMKELDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For chronic graft versus host disease – approve if the patient has tried at least one conventional systemic treatment (e.g. corticosteroids, Imbruvica).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IMBRUVICA

MEDICATION(S)
IMBRUVICA 140 MG CAPSULE, IMBRUVICA 140 MG TABLET, IMBRUVICA 280 MG TABLET, IMBRUVICA 420 MG TABLET, IMBRUVICA 70 MG CAPSULE, IMBRUVICA 70 MG/ML SUSPENSION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, previous therapies tried

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
1.Graft versus host disease (GVHD) – approve if the patient has tried one conventional systemic treatment for GVHD (e.g. corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib).
2.Adults with chronic lymphocytic leukemia (CLL)/small lymphocytic leukemia (SLL) – approve.
3.Adults with CLL/SLL with 17p deletion – approve.
4.Adult patients with Waldenstrom’s macroglobulinemia – approve.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

IMOVAX - PART D VS PART B

MEDICATION(S)

IMOVAX RABIES VACCINE

DETAILS

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

IMPAVIDO

MEDICATION(S)
IMPAVIDO

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

OFF LABEL USES
Amoeba related infections.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an infectious disease specialist

COVERAGE DURATION
1 month

OTHER CRITERIA
For Amoeba related infections: Approve if the patient is being treated for an infection due to one of the following: Acanthamoeba, Balamuthia mandrillaris, or Naegleria fowleri. Note: Examples of amoeba related infections are Acanthamoeba keratitis, granulomatous amoebic encephalitis (GAE), and primary amoebic meningoencephalitis (PAM).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INCRELEX

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use with growth hormone

REQUIRED MEDICAL INFORMATION
Diagnosis, response to therapy

AGE RESTRICTION
2 years and older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist

COVERAGE DURATION
1 year

OTHER CRITERIA
Treatment of growth failure in pediatric patients with severe primary IGF1 deficiency–Initial: Approve if patient meets all of the following (1, 2, 3, and 4): 1.The epiphyses are open, 2. Height standard deviation score is less than or equal to -3.0 at baseline (prior to initiation of Increlex), 3. Basal IGF-1 standard deviation score is less than or equal to -3.0 at baseline (prior to initiation of Increlex) (Note: Reference ranges for IGF-1 vary among laboratories and are dependent upon age, gender, and puberty status), 4. Growth hormone concentration is normal or increased at baseline. Continuation of therapy: the epiphyses are open and the patient continues to receive benefit with therapy, according to the prescriber's assessment. Treatment of growth failure in pediatric patients with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH: Initial: Approve if patient meets all of the following (1, 2, and 3): 1. The epiphyses are open, 2. Patient has a proven gene defect [examples include pathologic mutations in the GH receptor gene (Laron syndrome), signal transducer

and activator of transcription 5B (STAT5B) gene, or IGF1 gene], 3. Patient has developed neutralizing antibodies to growth hormone. Continuation of therapy: the epiphyses are open and the patient continues to receive benefit with therapy, according to the prescriber’s assessment

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

INLURIYO - EVICORE

MEDICATION(S)
INLURIYO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INLYTA - EVICORE

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INQOVI - EVICORE

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INREBIC - EVICORE

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INSULIN - APIDRA

MEDICATION(S)

APIDRA, APIDRA SOLOSTAR

PENDING CMS APPROVAL

INSULIN - HUMALOG ADMELOG LYUMJEV

MEDICATION(S)

ADMELOG, ADMELOG SOLOSTAR, HUMALOG, HUMALOG JUNIOR KWIKPEN, HUMALOG KWIKPEN U-100, HUMALOG KWIKPEN U-200, LYUMJEV, LYUMJEV KWIKPEN U-100, LYUMJEV KWIKPEN U-200

PENDING CMS APPROVAL

INSULIN - HUMALOG MIX

MEDICATION(S)

HUMALOG MIX 50-50 KWIKPEN, HUMALOG MIX 75-25, HUMALOG MIX 75-25 KWIKPEN

PENDING CMS APPROVAL

INTRALIPID - PART D VS PART B

MEDICATION(S)

INTRALIPID

DETAILS

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

INTRAROSA/OSPHENA

MEDICATION(S)
INTRAROSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IPRATROPIUM-ALBUTEROL - PART D VS PART B

MEDICATION(S)

IPRATROPIUM-ALBUTEROL

DETAILS

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

IPRATROPIUM - PART D VS PART B

MEDICATION(S)

IPRATROPIUM BR 0.02% SOLN

DETAILS

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

ITOVEBI - EVICORE

MEDICATION(S)
ITOVEBI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ITRACONAZOLE

MEDICATION(S)
ITRACONAZOLE 100 MG/10 ML CUP, ITRACONAZOLE 100 MG CAPSULE, ITRACONAZOLE 10 MG/ML SOLUTION

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

OFF LABEL USES
Superficial tinia, vaginal candidiasis.

EXCLUSION CRITERIA
Vaginal candidiasis hypersensitivity syndrome.

REQUIRED MEDICAL INFORMATION
Onychomycosis must be due to dermatophytes, and treatment must not be solely for cosmetic purposes as cosmetic use is excluded under Medicare Part D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
For blastomycosis, histoplasmosis and aspergillosis: 1 year. All other indications: Twelve weeks.

OTHER CRITERIA
Tinea or Pityrisis Versicolor requires one trial and failure of ketoconazole or a topical antifungal agent first. Tinea Capitis and Barbae require failure of one trial of griseofulvin or ketoconazole first. Tinea Cruris, Faciei, Manuum, Imbricata and Pedis (non moccasin or chronic type) require failure of one topical antifungal agent. Tinea Corporis requires failure of one topical antifungal agent first, except when condition is considered extensive. Vaginal Candidiases requires failure of both one topical antifungal regimen and one trial of oral fluconazole (patients of age less than 16 years are excluded from a trial of a topical vaginal antifungal preparation). For oral and esophageal candidiasis, must try and fail ketoconazole or fluconazole first. Itraconazole will be covered for other systemic infection if used for continuation of itraconazole therapy that has already been started and stabilized. Itraconazole

is covered first line when the prescriber is a Pulmonologist or an Infectious Disease physician.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

IVERMECTIN

MEDICATION(S)
IVERMECTIN 3 MG TABLET

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

OFF LABEL USES
Pediculosis, Scabies, Ascariasis, Enterobiasis (pinworm infection), Hookworm-related cutaneous larva migrans, Mansonella ozzardi infection, Mansonella streptocerca infection, Trichuriasis, and Wucheria bancrofti infections.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
30 days

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVIG

MEDICATION(S)

GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMMAGARD S-D, GAMUNEX-C, PRIVIGEN

PENDING CMS APPROVAL

IWILFIN - EVICORE

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JAKAFI

MEDICATION(S)
JAKAFI, JAKAFI XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JAYPIRCA

MEDICATION(S)
JAYPIRCA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Mantle Cell Lymphoma, Chronic lymphocytic lymphoma, small lymphocytic lymphoma – Approve if patient meets one of the following (1, 2, 3 or 4):
1.The patient has demonstrated a failure of or intolerance to one of the preferred products, Calquence and Brukinsa.
2.The patient has a documented contraindication to one of the preferred products, Calquence and Brukinsa.
3.The patient had an adverse reaction or would be reasonably expected to have an adverse reaction to one of the preferred products, Calquence and Brukinsa.
4.The patient has a clinical condition for which there is no listed preferred formulary alternatives to treat the condition based on published guidelines or clinical literature.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

JIDEYTRO - EVICORE

MEDICATION(S)

JIDEYTRO

PENDING CMS APPROVAL

JYLAMVO

MEDICATION(S)
JYLAMVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, Reason unable to take oral methotrexate (tablets)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
All requests will be subject to a Part B vs Part D review. Patient must meet one of the following (1, 2, 3 or 4): 1.Patient has demonstrated an intolerance to oral methotrexate (tablets) for the given diagnosis 2.Patient has a documented contraindication to oral methotrexate (tablets) 3.Patient has had an adverse reaction or would be reasonably expected to have an adverse reaction to oral methotrexate (tablets) 4.Patient has a clinical condition for which there is no listed preferred formulary alternative to treat the condition based on published guidelines or clinical literature.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

JYNARQUE

MEDICATION(S)

TOLVAPTAN

PENDING CMS APPROVAL

JYNNEOS - PART D VS PART B

MEDICATION(S)

JYNNEOS, JYNNEOS (NATIONAL STOCKPILE)

DETAILS

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

KALYDECO

MEDICATION(S)

KALYDECO

PENDING CMS APPROVAL

KERENDIA

MEDICATION(S)

KERENDIA

PENDING CMS APPROVAL

KEVZARA

MEDICATION(S)

KEVZARA

PENDING CMS APPROVAL

KINERET

MEDICATION(S)

KINERET

PENDING CMS APPROVAL

KISQALI - EVICORE

MEDICATION(S)
KISQALI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KORLYM

MEDICATION(S)
MIFEPRISTONE 300 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pregnancy.

REQUIRED MEDICAL INFORMATION
Diagnosis, reauth: positive response

AGE RESTRICTION
Aged 18 years or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist or specialist in treating Cushing’s syndrome

COVERAGE DURATION
Initial – 6 months, Continuation: 1 year

OTHER CRITERIA
The member must have failed surgery, or is not a candidate for surgery. Members must utilize adequate measures such as non-hormonal contraceptive methods to prevent pregnancy.Hyperglycemia secondary to hypercortisolism:
1.Initial – Approve if the patient meets all of the following (a, b, c and d):
a.Patient must have endogenous Cushing’s syndrome, requiring control of hyperglycemia secondary to hypercortisolism,
b.Patient has type 2 diabetes mellitus or glucose intolerance,
c.Patient has failed surgery or is not a candidate for surgery,
d.Patient must not be pregnant as evidenced by a documented negative pregnancy test prior to the initiation of treatment and must use adequate measures such as non-hormonal contraceptive methods to prevent pregnancy.

2.Continuation: Approve if the patient meets all of the following (a and b):
a.If patient is new to plan, must have met initial criteria at time of starting the medication,
b.Patient must have experienced a beneficial response from therapy (e.g. improvement in fasting glucose, oral glucose tolerance or hemoglobin A1c results)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

KOSELUGO - EVICORE

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KRAZATI - EVICORE

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KUVAN

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE, ZELVYSIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use with Palynziq (continuation only)

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial 3 months, if positive response, then 1 year. In pregnancy, through term.

OTHER CRITERIA
For continuation of therapy, allow for continuation of therapy if the patient has experienced improvement after the initial three months of therapy, as determined by the prescriber.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAPATINIB - EVICORE

MEDICATION(S)
LAPATINIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAZCLUZE - EVICORE

MEDICATION(S)
LAZCLUZE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LENALIDOMIDE - EVICORE

MEDICATION(S)
LENALIDOMIDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LENVIMA - EVICORE

MEDICATION(S)
LENVIMA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEQEMBI IQLIK

MEDICATION(S)

LEQEMBI IQLIK

PENDING CMS APPROVAL

LEUKERAN - EVICORE

MEDICATION(S)
LEUKERAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEUKINE

MEDICATION(S)
LEUKINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEUPROLIDE - EVICORE

MEDICATION(S)
LEUPROLIDE 2WK 14 MG/2.8 ML KT, LEUPROLIDE 2WK 14 MG/2.8 ML VL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEVALBUTEROL - PART D VS PART B

MEDICATION(S)

LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL

DETAILS

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

LIFYORLI - EVICORE

MEDICATION(S)
LIFYORLI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LIVTENCITY

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with ganciclovir or valganciclovir

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
12 years and older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist, infectious disease specialist, oncologist, or a physician affiliated with a transplant center.

COVERAGE DURATION
2 months

OTHER CRITERIA
Cytomegalovirus Infection, Treatment-approve if the patient meets the following criteria (A, B, and C): A) Patient weighs greater than or equal to 35 kg, AND B) Patient is post-transplant (Note: This includes patients who are post hematopoietic stem cell transplant or solid organ transplant.) AND C) Patient has cytomegalovirus infection/disease that is refractory to treatment with at least one of the following: cidofovir, foscarnet, ganciclovir, or valganciclovir

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

LOMUSTINE - EVICORE

MEDICATION(S)
LOMUSTINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LONSURF - EVICORE

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LORBRENA - EVICORE

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUMAKRAS - EVICORE

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUPRON DEPOT

MEDICATION(S)

LUPRON DEPOT, LUPRON DEPOT (LUPANETA)

PENDING CMS APPROVAL

LYNPARZA - EVICORE

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LYTGOBI - EVICORE

MEDICATION(S)
LYTGOBI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MAVYRET

MEDICATION(S)
MAVYRET

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

OFF LABEL USES
Indications consistent with current AASLD/IDSA guidance

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Member has been tested for evidence of current or prior hepatitis B virus (HBV) infection before initiating treatment with Mavyret.

AGE RESTRICTION
Member is 3 years of age or older.

PRESCRIBER RESTRICTION
The medication must be prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.

COVERAGE DURATION
8, 12, or 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEKINIST - EVICORE

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEKTOVI - EVICORE

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEMANTINE

MEDICATION(S)

MEMANTINE HCL 10 MG/5 ML CUP, MEMANTINE HCL 2 MG/ML SOLUTION

PENDING CMS APPROVAL

METHOTREXATE - PART D VS PART B

MEDICATION(S)

METHOTREXATE 2.5 MG TABLET

DETAILS

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

MODAFINIL

MEDICATION(S)

MODAFINIL 100 MG TABLET, MODAFINIL 200 MG TABLET

PENDING CMS APPROVAL

MODEYSO - EVICORE

MEDICATION(S)
MODEYSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MYCOPHENOLATE - PART D VS PART B

MEDICATION(S)

MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET

DETAILS

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

MYCOPHENOLIC ACID - PART D VS PART B

MEDICATION(S)

MYCOPHENOLIC ACID

DETAILS

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

NASAL CORTICOSTEROID - MOMETASONE

MEDICATION(S)

MOMETASONE FUROATE 50 MCG SPRY

PENDING CMS APPROVAL

NASAL CORTICOSTEROID - RYALTRIS

MEDICATION(S)

RYALTRIS

PENDING CMS APPROVAL

NERLYNX - EVICORE

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NEXLETOL

MEDICATION(S)

NEXLETOL

PENDING CMS APPROVAL

NEXLIZET

MEDICATION(S)

NEXLIZET

PENDING CMS APPROVAL

NILOTINIB - EVICORE

MEDICATION(S)
CAVHANZA, NILOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NINLARO - EVICORE

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NITISINONE

MEDICATION(S)
NITISINONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)

COVERAGE DURATION
1 year

OTHER CRITERIA
Hereditary Tyrosinemia, Type 1 – approve if diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NUBEQA - EVICORE

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NUCALA

MEDICATION(S)

NUCALA

PENDING CMS APPROVAL

NUEDEXTA

MEDICATION(S)

DEXTROMETHORPHAN HBR-QUINIDINE

PENDING CMS APPROVAL

NUPLAZID

MEDICATION(S)

NUPLAZID

PENDING CMS APPROVAL

NURTEC ODT

MEDICATION(S)
NURTEC ODT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
For preventative treatment: Combination with a CGRP antagonist when the CGRP antagonist is being used for prophylaxis.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Acute treatment: Approve if the patient has trialed and failed two different triptans (must be different active ingredients and documentation required) or has an intolerance or contraindication [documentation required] to triptans. Contraindications to triptans include history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, and other vascular risk factors or disorders. Preventative treatment of episodic migraine: For: Approve if the patient has a diagnosis of episodic migraine.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

NYVEPRIA - EVICORE

MEDICATION(S)
NYVEPRIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ODOMZO - EVICORE

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OGSIVEO - EVICORE

MEDICATION(S)
OGSIVEO 100 MG TABLET, OGSIVEO 150 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OJEMDA - EVICORE

MEDICATION(S)
OJEMDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OJJAARA - EVICORE

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OMNIPOD

MEDICATION(S)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5), OMNIPOD 5 DEXG7G6 PODS (GEN 5), OMNIPOD 5 G6-G7 INTRO KT(GEN5), OMNIPOD 5 G6-G7 PODS (GEN 5), OMNIPOD DASH INTRO KIT (GEN 4), OMNIPOD DASH PODS (GEN 4)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, insulin therapy regimen

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 years

OTHER CRITERIA
Patient must meet ALL of the following requirements (A, B, C, and D):

A. Diagnosis of diabetes, as indicated by 1 or more of the following (1 or 2):

(1.) Type 1 diabetes mellitus OR

(2.) Type 2 diabetes mellitus and 1 or more of the following (a. or b.): (a.) Daily insulin requirement of 0.7 to 1.8 units per kg or (b.) Total daily insulin dose is 220 units or less

B. Failure of multiple daily injection insulin administration, as indicated by 1 or more of the following:

(1.) Abnormal early-morning increase in blood glucose (“dawn phenomenon”), unresponsive to management with long-acting insulin analogue (eg, insulin glargine, insulin detemir) regimens

(2.) Child for whom multiple daily insulin injections are impractical or inappropriate

(3.) Diabetes complications (eg, neuropathy, nephropathy, retinopathy), and need for more intensive management

(4.) Extreme insulin sensitivity

(5.) HbA1c greater than 7% (53 mmol/mol), despite intensified multiple daily injection insulin therapy

(6.) Hypoglycemia requiring third-party assistance, including unconsciousness, seizure, glucagon administration, and emergency attendance or admission to hospital

(7.) Patient is pregnant or planning pregnancy

(8.) Wide swings in glycemic control

C. Patient or caregiver is motivated, adherent, knowledgeable, and able to monitor blood glucose 3 or more times per day.

D. Provider team is experienced and expert in management and support of patient with insulin pumps

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ONDANSETRON - PART D VS PART B

MEDICATION(S)

ONDANSETRON 4 MG/5 ML SOLN CUP, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT 4 MG TABLET, ONDANSETRON ODT 8 MG TABLET

DETAILS

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

ONUREG - EVICORE

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OPHTHALMIC BETA BLOCKER

MEDICATION(S)

TIMOLOL MALEATE PF EYE DROPS 0.25%, TIMOLOL MALEATE PF EYE DROPS 0.5%

PENDING CMS APPROVAL

OPHTHALMIC PROSTAGLANDIN - BIMATOPROST

MEDICATION(S)

BIMATOPROST 0.01% EYE DROPS

PENDING CMS APPROVAL

OPHTHALMIC PROSTAGLANDIN - ROCKLATAN

MEDICATION(S)

ROCKLATAN

PENDING CMS APPROVAL

OPHTHALMIC PROSTAGLANDIN - TAFLUPROST

MEDICATION(S)

TAFLUPROST

PENDING CMS APPROVAL

OPHTHALMIC PROSTAGLANDIN - TRAVOPROST

MEDICATION(S)

TRAVOPROST

PENDING CMS APPROVAL

OPHTHALMIC PROSTAGLANDIN - VYZULTA

MEDICATION(S)

VYZULTA

PENDING CMS APPROVAL

ORGOVYX - EVICORE

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ORKAMBI

MEDICATION(S)

ORKAMBI

PENDING CMS APPROVAL

ORSERDU - EVICORE

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OTEZLA

MEDICATION(S)

OTEZLA 10-20-30MG START 28 DAY, OTEZLA 10-20 MG STARTER 28 DAY, OTEZLA 20 MG TABLET, OTEZLA 30 MG TABLET, OTEZLA XR

PENDING CMS APPROVAL

PANRETIN - EVICORE

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PARATHYROID HORMONE AGENTS - TERIPARATIDE

MEDICATION(S)

TERIPARATIDE

PENDING CMS APPROVAL

PARATHYROID HORMONE AGENTS - TYMLOS

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with pre-existing hypercalcemia or primary hyperparathyroidism

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 years

OTHER CRITERIA
Patient must meet one of the following (1 or 2):
1) Use is for treatment of postmenopausal women with osteoporosis at high risk for fracture (defined as a history of osteoporotic fracture or multiple risk factors for fracture), or patients who have failed or are intolerant to other available osteoporosis therapy (e.g. oral or IV bisphosphonates, denosumab) OR
2) Use is to increase bone density in men with osteoporosis at high risk for fracture (defined as a history of osteoporotic fracture or multiple risk factors for fracture), or patients who have failed or are intolerant to other available osteoporosis therapy (e.g. oral or IV bisphosphonates, denosumab).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

PART D VS PART B

MEDICATION(S)

CLINIMIX 6%-5% SOLUTION, CLINIMIX 8%-10% SOLUTION, CLINIMIX 8%-14% SOLUTION, CLINIMIX E 8%-10% SOLUTION, CLINIMIX E 8%-14% SOLUTION, ENVARSUS XR, FOSCARNET SODIUM, GANCICLOVIR SODIUM, TACROLIMUS 5 MG/ML VIAL, VINCASAR PFS, VINCRISTINE SULFATE

DETAILS

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

PAZOPANIB - EVICORE

MEDICATION(S)
PAZOPANIB HCL 200 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEMAZYRE - EVICORE

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PENTAMIDINE - PART D VS PART B

MEDICATION(S)

PENTAMIDINE 300 MG INHAL POWDR

DETAILS

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

PHOSPHATE BINDERS - CALCIUM ACETATE

MEDICATION(S)
CALCIUM ACETATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients on dialysis [non-Part D use]

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHOSPHATE BINDERS - SEVELAMER

MEDICATION(S)
SEVELAMER CARBONATE 800 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients on dialysis [non-Part D use]

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIQRAY - EVICORE

MEDICATION(S)
PIQRAY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PLENAMINE - PART D VS PART B

MEDICATION(S)

PLENAMINE

DETAILS

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

POMALYST - EVICORE

MEDICATION(S)

POMALIDOMIDE, POMALYST

PENDING CMS APPROVAL

PREMASOL - PART D VS PART B

MEDICATION(S)

PREMASOL

DETAILS

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

PREVYMIS

MEDICATION(S)

PREVYMIS 120 MG PELLET PACKET, PREVYMIS 20 MG PELLET PACKET, PREVYMIS 240 MG TABLET, PREVYMIS 480 MG TABLET

PENDING CMS APPROVAL

PROMACTA

MEDICATION(S)

ELTROMBOPAG OLAMINE

PENDING CMS APPROVAL

PROSOL - PART D VS PART B

MEDICATION(S)

PROSOL

DETAILS

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

PULMOZYME - PART D VS PART B

MEDICATION(S)

PULMOZYME

DETAILS

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

QINLOCK - EVICORE

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

QULIPTA

MEDICATION(S)

QULIPTA

PENDING CMS APPROVAL

RABAVERT - PART D VS PART B

MEDICATION(S)

RABAVERT

DETAILS

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

RETACRIT

MEDICATION(S)

RETACRIT

PENDING CMS APPROVAL

RETEVMO - EVICORE

MEDICATION(S)
RETEVMO 120 MG TABLET, RETEVMO 160 MG TABLET, RETEVMO 40 MG TABLET, RETEVMO 80 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, genetic tests.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with, an immunologist, hematologist/oncologist, or physician that specializes in ADA-SCID or related disorders.

COVERAGE DURATION
12 months

OTHER CRITERIA
ADA-SCID - approve if the patient had absent or very low (less than 1% of normal) ADA catalytic activity at baseline (i.e., prior to initiating enzyme replacement therapy) OR if the patient had molecular genetic testing confirming bi-allelic mutations in the ADA gene.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REVUFORJ - EVICORE

MEDICATION(S)
REVUFORJ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REYVOW

MEDICATION(S)
REYVOW

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Approve if the patient has trialed and failed or has a contraindication [documentation required] Nurtec ODT.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REZDIFFRA

MEDICATION(S)

REZDIFFRA

PENDING CMS APPROVAL

REZLIDHIA - EVICORE

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REZUROCK

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Moderate to severe hepatic impairment (Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION
Diagnosis.

AGE RESTRICTION
12 years and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Patient has chronic GVHD and has history of failure, intolerance or contraindication to BOTH Imbruvica and Jakafi

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RHOPRESSA

MEDICATION(S)
RHOPRESSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prior therapies

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Member must try and fail latanoprost AND one Ophthalmic Beta Blocker (ex. Timolol, betaxolol, levobunolol, metipranolol) prior to Rhopressa therapy

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RILUTEK

MEDICATION(S)

TEGLUTIK, TIGLUTIK

PENDING CMS APPROVAL

RINVOQ

MEDICATION(S)

RINVOQ

PENDING CMS APPROVAL

ROMVIMZA - EVICORE

MEDICATION(S)
ROMVIMZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ROZLYTREK - EVICORE

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUBRACA - EVICORE

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RYDAPT - EVICORE

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SANDOSTATIN

MEDICATION(S)

OCTREOTIDE ACETATE, OCTREOTIDE ACETATE ER

PENDING CMS APPROVAL

SARCLISA ESCENA - EVICORE

MEDICATION(S)

SARCLISA ESCENA

PENDING CMS APPROVAL

SCEMBLIX - EVICORE

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SCIG

MEDICATION(S)
CUVITRU, HIZENTRA, HYQVIA, XEMBIFY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, Reauth: positive clinical response

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP: prescribed by or in consultation with a neurologist.

COVERAGE DURATION
PI initial and continuation: 1 year. CIDP initial: 3 months, continuation: 1 year.

OTHER CRITERIA
All requests will be subject to a Part B vs Part D review. If patient is new to plan, must meet initial criteria at time they had started the medication. Documented dose and frequency must be within the FDA approved dosing and frequency or consistent with compendial sources (e.g. Micromedex, current clinical guidelines, etc.). PI: Initial therapy: Approve if pt meets ONE of the following (1, 2 or 3): 1. Pt has diagnosis of congenital agammaglobulinemia, X-linked agammaglobulinemia, other agammaglobulinemia due to absence of B-cells, Wiskott-Aldrich syndrome, ataxia telangiectasia, DiGeorge syndrome, severe combined immunodeficiency, Hyper-Immunoglobulin M (IgM) syndromes, an IgG level lower than 250 mg/dL, or a primary immune deficiency which has been confirmed by genetic or molecular testing OR 2. Pt has a diagnosis of common variable immunodeficiency, unspecified hypogammaglobulinemia, or other immunodeficiencies with significant hypogammaglobulinemia and meets the following (a and b) a. Pts pretreatment IgG level is below

normal range (age-adjusted and according to normal reference range for reporting laboratory AND b. Pt has an impaired antibody response (i.e. failure to produce antibodies to specific antigens) OR pt has recurrent infections OR 3. Pt has an IgG subclass deficiency, selective antibody deficiency (SAD), or other confirmed primary immunodeficiency and meets the following (a and b): a. Pt has an impaired antibody response (i.e. failure to produce antibodies to specific antigens) AND b. Patient has recurrent infections. PI Continuation of therapy: Approve if pt has been diagnosed with PI and, according to the prescriber, the pt is continuing to receive benefit from the product (e.g. increased IgG levels or prevention and/or controlling of infections). CIDP or Polyradiculoneuropathy: Initial therapy: Approve if member meets following criteria (i, ii and iii) i. Member has had progressive symptoms present for at least 2 months ii. Has had symptomatic polyradiculoneuropathy with progressive or relapsing motor or sensory impairment in more than one limb iii. Member meets at least three of the following electrodiagnostic criteria for CIDP diagnosis (1, 2, 3 and/or 4): 1. Partial conduction block of one or more motor nerve, 2. Reduced conduction velocity of 2 or more motor nerves, 3. Prolonged distal latency of 2 or more motor nerves, 4. Prolonged F-wave latencies of 2 or more nerves or absence of F waves. CIDP Continuation therapy: Approve if pt has had clinically significant improvement to treatment as measured by an objective scale (e.g. Rankin, Modified Rankin, Medical Research Council [MRC] scale).

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SIGNIFOR

MEDICATION(S)

SIGNIFOR

PENDING CMS APPROVAL

SILDENAFIL

MEDICATION(S)
SILDENAFIL 20 MG TABLET

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

OFF LABEL USES
Raynaud’s phenomenon

EXCLUSION CRITERIA
Erectile dysfunction. Benign Prostatic hyperplasia.

REQUIRED MEDICAL INFORMATION
Diagnosis, previous medication trials (if applicable)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
Pulmonary arterial hypertension – approve if member has confirmed diagnosis of PAH [documentation required]. Raynaud’s phenomenon – approve if the member meets both of the following (a and b): a. Member has confirmed diagnosis of Raynaud’s phenomenon [documentation required], AND b. Member has a previous trial, intolerance or contraindication to a calcium channel blocker, such as amlodipine or nifedipine.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SIMBRINZA

MEDICATION(S)

SIMBRINZA

PENDING CMS APPROVAL

SIROLIMUS - PART D VS PART B

MEDICATION(S)

SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET

DETAILS

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

SODIUM OXYBATE PRODUCTS

MEDICATION(S)

SODIUM OXYBATE

PENDING CMS APPROVAL

SOMAVERT

MEDICATION(S)

SOMAVERT

PENDING CMS APPROVAL

SORAFENIB - EVICORE

MEDICATION(S)
SORAFENIB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOVALDI

MEDICATION(S)
SOVALDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years or older. 3 and older in Genotype 2 and 3

PRESCRIBER RESTRICTION
Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD

COVERAGE DURATION
12 wk, 16 wk, 24 wk, or 48 wk. Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

STELARA

MEDICATION(S)

SELARSDI 45 MG/0.5 ML SYRINGE, SELARSDI 45 MG/0.5 ML VIAL, SELARSDI 90 MG/ML SYRINGE, STARJEMZA 45 MG/0.5 ML SYRINGE, STARJEMZA 45 MG/0.5 ML VIAL, STARJEMZA 90 MG/ML SYRINGE, YESINTEK 45 MG/0.5 ML SYRINGE, YESINTEK 45 MG/0.5 ML VIAL, YESINTEK 90 MG/ML SYRINGE

PENDING CMS APPROVAL

STIMUFEND - EVICORE

MEDICATION(S)
STIMUFEND

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

STIVARGA - EVICORE

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

STRENSIQ

MEDICATION(S)
STRENSIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, lab values, radiographic reports

AGE RESTRICTION
Disease onset-less than or equal to 18

PRESCRIBER RESTRICTION
Prescribed by an endocrinologist or specialist experienced in treatment of metabolic bone disorders

COVERAGE DURATION
Initial – 6 months. Continuation – 12 months.

OTHER CRITERIA
Initial Coverage – member meets all of the following requirements (1, 2 and 3): 1. Documented diagnosis of perinatal/infantile- or juvenile-onset hypophosphatasia (HPP) AND diagnosis supported by one of the following (a or b): a. Molecular genetic testing documenting tissue non-specific alkaline phosphatase (ALPL) gene mutation OR b. Documentation of ALL of the following (i, ii and iii): i. An elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi] level) ii. Findings on radiographic imaging support diagnosis of hypophosphatasia (e.g. infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age [as detected by DXA scan])

iii. Low baseline ALP activity (age adjusted), 2. Member is 18 years or less at age of disease onset 3.

Member has clinical manifestations consistent with hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures). Continuation of coverage – member meets the following (1, 2 and 3) 1. Member meets criteria for initial approval, 2. Documentation of positive clinical response to Strensiq (e.g. improvement in clinical symptoms, improvement in Radiographic Global Impression of Change), 3. Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase (TNSALP) substrate (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi] level).

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SUNITINIB - EVICORE

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TABRECTA - EVICORE

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TACROLIMUS - PART D VS PART B

MEDICATION(S)

PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 0.5 MG CAPSULE (IR), TACROLIMUS 1 MG CAPSULE, TACROLIMUS 1 MG CAPSULE (IR), TACROLIMUS 5 MG CAPSULE, TACROLIMUS 5 MG CAPSULE (IR), TACROLIMUS XL

DETAILS

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

TADALAFIL

MEDICATION(S)
ALYQ, TADALAFIL 20 MG TABLET

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

OFF LABEL USES
Raynaud's phenomenon

EXCLUSION CRITERIA
Erectile dysfunction. Benign Prostatic hyperplasia.

REQUIRED MEDICAL INFORMATION
Diagnosis, previous medication trials (if applicable)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
Pulmonary arterial hypertension – approve if member has confirmed diagnosis of PAH [documentation required]. Raynaud’s phenomenon – approve if the member meets both of the following (a and b): a. Member has confirmed diagnosis of Raynaud’s phenomenon [documentation required], AND b. Member has a previous trial, intolerance or contraindication to a calcium channel blocker, such as amlodipine or nifedipine.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TAFINLAR - EVICORE

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TAGRISSO - EVICORE

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TALZENNA - EVICORE

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TARPEYO

MEDICATION(S)

TARPEYO

PENDING CMS APPROVAL

TAZAROTENE

MEDICATION(S)
TAZAROTENE 0.1% CREAM, TAZAROTENE 0.1% GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pregnancy. Fine wrinkle disorder/fine wrinkles on face.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime.

OTHER CRITERIA
Diagnosis of acne vulgaris requires failure on at least two other formulary anti-acne preparations (e.g. topical retinoid products, topical antibacterial products). Members must utilize adequate measures to prevent pregnancy.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TEPMETKO - EVICORE

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TESTOSTERONE

MEDICATION(S)
TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT

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

OFF LABEL USES
Gender dysphoria in transgender male patients.

EXCLUSION CRITERIA
Erectile dysfunction. Decreased Libido.

REQUIRED MEDICAL INFORMATION
Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]

AGE RESTRICTION
Aged 18 years or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime.

OTHER CRITERIA
Hypogonadism (primary or secondary) in males initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined

by the normal laboratory reference values. Hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

TEZSPIRE

MEDICATION(S)

TEZSPIRE

PENDING CMS APPROVAL

THALOMID

MEDICATION(S)
THALOMID 100 MG CAPSULE, THALOMID 50 MG CAPSULE

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

OFF LABEL USES
Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Kaposis sarcoma, Castlemans Disease, Histiocytic neoplasms

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, previous therapies tried

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For Erythem Nodosum Leprosum approve. For Multiple myeloma approve if Thalomid is being taken in combination with dexamethasone. For Discoid lupus erythematosus or cutaneous lupus erythematosus approve if the patient has tried at least two other therapies (e.g. corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). For Myelofibrosis approve if, according to the prescriber, the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/ml OR the patient has serum erythropoietin levels less than 500 mU/ml and no response or loss of response to erythropoietic stimulating agents. For Prurigo nodularis approve. For Recurrent aphthous ulcers or aphthous stomatitis approve if the patient has tried at least two other therapies (e.g. topical or intralesional

corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [e.g. benzocaine lozenges], antimicrobial mouthwashes [e.g. tetracycline], acyclovir, colchicine) 7.Kaposis sarcoma approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease 8.Castlemans disease approve if patient meets ALL of the following criteria: a. Has multicentric Castlemans disease AND b. Is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8). Histiocytic neoplasms – approve if the patient has Langerhans cell histiocytosis with single-system multifocal skin disease or Rosai-Dorfman cutaneous disease.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

TIBSOVO - EVICORE

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOBRAMYCIN - PART D VS PART B

MEDICATION(S)

TOBRAMYCIN 300 MG/4 ML AMPULE, TOBRAMYCIN 300 MG/5 ML AMPULE

DETAILS

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

TOPICAL ALPHA-ADRENERGIC AGENTS FOR ROSACEA

MEDICATION(S)
BRIMONIDINE 0.33% GEL PUMP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL RETINOIDS - ADAPALENE

MEDICATION(S)
ADAPALENE 0.1% CREAM, ADAPALENE 0.3% GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Coverage is not provided for cosmetic use.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL RETINOIDS - AKLIEF

MEDICATION(S)
AKLIEF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Coverage is not provided for cosmetic use.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
Member has a previous trial and failure or intolerance to a generic topical retinoid product, such as adapalene or tretinoin

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TOPICAL RETINOIDS - TRETINOIN

MEDICATION(S)
TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.1% CREAM, TRETINOIN GEL MICRO 0.04% PUMP, TRETINOIN GEL MICRO 0.04% TUBE, TRETINOIN GEL MICRO 0.08% PUMP, TRETINOIN GEL MICRO 0.1% PUMP, TRETINOIN GEL MICRO 0.1% TUBE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Coverage is not provided for cosmetic use.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TORPENZ - EVICORE

MEDICATION(S)
TORPENZ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRAVASOL - PART D VS PART B

MEDICATION(S)

TRAVASOL

DETAILS

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

TRELSTAR - EVICORE

MEDICATION(S)
TRELSTAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TREMFYA

MEDICATION(S)

TREMFYA 100 MG/ML SYRINGE, TREMFYA 200 MG/2 ML SYRINGE, TREMFYA ONE-PRESS, TREMFYA PEN, TREMFYA PEN INDUCTION (2 PEN)

PENDING CMS APPROVAL

TRETINOIN - EVICORE

MEDICATION(S)
TRETINOIN 10 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIKAFTA

MEDICATION(S)

TRIKAFTA

PENDING CMS APPROVAL

TRINTELLIX

MEDICATION(S)
TRINTELLIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lifetime

OTHER CRITERIA
For Major depressive disorder: Member must have tried and failed one generic serotonin selective reuptake inhibitor (SSRI)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRIPTAN THERAPY

MEDICATION(S)

ZOLMITRIPTAN 2.5MG NASAL SPRAY, ZOLMITRIPTAN 2.5 MG NASAL SPRY, ZOLMITRIPTAN 5 MG NASAL SPRAY

PENDING CMS APPROVAL

TROPHAMINE - PART D VS PART B

MEDICATION(S)

TROPHAMINE

DETAILS

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

TRUQAP - EVICORE

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TUKYSA - EVICORE

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TURALIO - EVICORE

MEDICATION(S)
TURALIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

UBRELVY

MEDICATION(S)
UBRELVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
For acute treatment: Combination with a CGRP antagonist when the CGRP antagonist is being used for acute treatment.

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Approve if the patient has trialed and failed or has a contraindication [documentation required] to Nurtec ODT.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

UPTRAVI

MEDICATION(S)

UPTRAVI 1,000 MCG TABLET, UPTRAVI 100 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 150 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 200 MCG TABLET, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET

PENDING CMS APPROVAL

VALCHLOR - EVICORE

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VANFLYTA - EVICORE

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VELSIPITY

MEDICATION(S)

VELSIPITY

PENDING CMS APPROVAL

VENCLEXTA - EVICORE

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VEOZAH

MEDICATION(S)

VEOZAH

PENDING CMS APPROVAL

VEPPANU - EVICORE

MEDICATION(S)
VEPPANU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VERZENIO - EVICORE

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VITRAKVI - EVICORE

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VIZIMPRO - EVICORE

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VONJO - EVICORE

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VOQUEZNA DUAL PAK

MEDICATION(S)
VOQUEZNA DUAL PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use with rilpivirine-containing products, eGFR less than 30 mL/min, Moderate to severe hepatic impairment (Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION
Diagnosis, previous medications trialed as described in other criteria

AGE RESTRICTION
Patient is 18 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Treatment of H pylori: 1 month

OTHER CRITERIA
Treatment of H. pylori in combination with amoxicillin or amoxicillin and clarithromycin– approve if member meets one of the following (1 or 2):
1.Member has documented intolerance or inadequate response to TWO or more proton pump inhibitors (PPIs) with twice-daily dosing (with the exception of dexlansoprazole), OR
2.Member has documented contraindication or would be reasonably expected to have an adverse reaction to use of all the preferred products, including dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole and rabeprazole. Documentation including the medication name(s) and contraindication or adverse reaction is required

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

VOQUEZNA TRIPLE PAK

MEDICATION(S)

VOQUEZNA TRIPLE PAK

PENDING CMS APPROVAL

VORANIGO - EVICORE

MEDICATION(S)
VORANIGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VOSEVI

MEDICATION(S)

VOSEVI

PENDING CMS APPROVAL

VOWST

MEDICATION(S)

VOWST

PENDING CMS APPROVAL

WEGOVY

MEDICATION(S)

WEGOVY

PENDING CMS APPROVAL

WELIREG - EVICORE

MEDICATION(S)
WELIREG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

WINREVAIR

MEDICATION(S)

WINREVAIR, WINREVAIR (2 PACK)

PENDING CMS APPROVAL

XALKORI - EVICORE

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XDEMVY

MEDICATION(S)

XDEMVY

PENDING CMS APPROVAL

XELJANZ

MEDICATION(S)

TOFACITINIB 10 MG TABLET, TOFACITINIB 1 MG/ML SOLUTION, TOFACITINIB 5 MG TABLET, TOFACITINIB CITRATE ER

PENDING CMS APPROVAL

XENAZINE

MEDICATION(S)

TETRABENAZINE

PENDING CMS APPROVAL

XERMELO - EVICORE

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XIFAXAN

MEDICATION(S)

XIFAXAN

PENDING CMS APPROVAL

XOLAIR

MEDICATION(S)

XOLAIR

PENDING CMS APPROVAL

XOSPATA - EVICORE

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XPOVIO - EVICORE

MEDICATION(S)
XPOVIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XTANDI - EVICORE

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZEJULA - EVICORE

MEDICATION(S)
ZEJULA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD)-positive status– Approve if patient meets one of the following:
1.The patient has an intolerance to the preferred product, Lynparza.
2.The patient has a documented contraindication to Lynparza
3.The patient had an adverse reaction or would be reasonably expected to have an adverse reaction to Lynparza
4.The patient has a clinical condition for which there is no listed preferred formulary alternatives to treat the condition based on published guidelines or clinical literature.

Maintenance treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy– Approve if patient meets one of the following:
1.The patient has an intolerance to one of the preferred products, Lynparza or Rubraca.
2.The patient has a documented contraindication to one of the preferred products, Lynparza or Rubraca.
3.The patient had an adverse reaction or would be reasonably expected to have an adverse reaction to one of the preferred products, Lynparza or Rubraca.
4.The patient has a clinical condition for which there is no listed preferred formulary alternatives to treat the condition based on published guidelines or clinical literature.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

ZELBORAF - EVICORE

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZENBEXUS - EVICORE

MEDICATION(S)

ZENBEXUS

PENDING CMS APPROVAL

ZEPATIER

MEDICATION(S)
ZEPATIER

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

OFF LABEL USES
Indications consistent with current AASLD/IDSA guidance

EXCLUSION CRITERIA
Combination use with other direct acting antivirals, excluding Sovaldi and ribavirin.

REQUIRED MEDICAL INFORMATION
Hep C genotype, concurrent medications, medication history to include preferred product as outlined in other criteria

AGE RESTRICTION
12 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation w/ GI, hepatologist, ID, or liver transplant MD.

COVERAGE DURATION
Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. Harvoni, Epclusa, Sovaldi, Vosevi and Mavyret are the preferred products. Authorization for Zepatier requires that the member must have confirmation of one of the following: A documented failure to one of the preferred products, OR A documented intolerance to one the preferred products, OR A documented contraindication to one of the preferred products, OR A documented adverse reaction to one of the preferred products.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

ZOLINZA - EVICORE

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZORYVE

MEDICATION(S)

ZORYVE

PENDING CMS APPROVAL

ZTALMY

MEDICATION(S)

ZTALMY

PENDING CMS APPROVAL

ZURZUVAE

MEDICATION(S)

ZURZUVAE

PENDING CMS APPROVAL

ZYDELIG - EVICORE

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZYKADIA - EVICORE

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZYMFENTRA

MEDICATION(S)

ZYMFENTRA, ZYMFENTRA PEN

PENDING CMS APPROVAL