You can contact CarePlus for the most recent list of drugs by calling 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. You may also visit www.careplushealthplans.com.

This document applies to the following CarePlus Plans:

Plan	Market	Formulary ID	Version
H1019043	Treasure and Space Coast	20457	17
H1019065	South Florida: Broward, Palm Beach	20457	17
H1019069	North Florida	20458	16
H1019073	North Florida	20457	17
H1019085	North Florida	20457	17
H1019090	Treasure and Space Coast	20457	17
H1019091	Treasure and Space Coast	20457	17
H1019094	North Florida	20457	17

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
2TEK GLUCOSE/BLOOD PRESSURE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ABIRATERONE		Members with severe hepatic impairment (Child-Pugh Class C). Members that have experienced disease progression while on abiraterone acetate.Concomitant use with Erleada, Xtandi, Provenge,	Prostate Cancer (mCRPC). The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC). The member will be using abiraterone acetate in combination with prednisone. Prostate Cancer (mCSPC). The member has diagnosis of castration-sensitive prostate cancer plus one of the following scenarios: metastatic (stage IV) disease AND is high risk (e.g. Gleason score of 8 or more, at least three bone lesions, or presence of measurable visceral metastases) OR Node-positive (any T, N1)		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Taxotere or Jevtana.	OR localized disease with high risk features (e.g. a PSA level greater than 4 ng per milliliter with a doubling time of less than 6 months, a PSA level greater than 20 ng per milliliter, nodal or metastatic relapse, or adjuvant or neoadjuvant therapy lasting less than 12 months of total ADT and completed at least 12 months previously) that is persistent or recurrent after prior radical prostatectomy and/or radiation therapy. Member will be using abiraterone acetate in combination with prednisone and one of the following applies: in combination with LHRH analog (e.g, Lupron, Trelstar) OR has previous bilateral orchiectomy.				
ABRAXANE			Breast Cancer. The member has a diagnosis of metastatic (Stage IV) or recurrent breast cancer. The member received prior therapy that included an anthracycline (unless contraindicated). The member has documented hypersensitivity reaction to conventional Taxol or Taxotere or the member has a		Licensed Practitioner	6 months duration	Ovarian Cancer. The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer or primary peritoneal cancer. The member meets one of the following criteria: Progressive, stable or persistent disease on primary

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			documented contraindication to standard hypersensitivity premedications OR member has a diagnosis of unresectable locally advanced or metastatic triple negative breast cancer AND all of the following apply: disease is PD-L1 positive (e.g. PD-L1 expression covering greater than or equal to 1% of the tumor area) and Abraxane is given in combo with Tecentriq. Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of locally advanced, recurrent or metastatic NSCLC. Member has documented hypersensitivity reaction to conventional Taxol or Taxotere or the member has a documented contraindication to standard hypersensitivity premedications AND member has squamous histology where Abraxane will be given in combo with Keytruda and carboplatin as first line therapy OR member will be using Abraxane as monotherapy or in combo with carboplatin AND One of the following apply: will be using for first line therapy OR member will be using as subsequent				chemotherapy. Recurrent disease. The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol) or the member has a documented contraindication to standard hypersensitivity premedications. Pancreatic Cancer: The member has a diagnosis of pancreatic cancer and Abraxane is being used in combination with gemcitabine as neoadjuvant therapy or The member has a diagnosis of metastatic pancreatic cancer AND The member will be using Abraxane in combination with gemcitabine. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member will be using Abraxane (nab-

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			therapy for EGFR mutation-positive tumors after prior therapy with erlotinib, afatinib, or gefitinib OR The member will be using as subsequent therapy for ALK-positive tumors after prior therapy with crizotinib, ceritinib, alectinib, or brigatinib OR member will be using as subsequent therapy for ROS-1 positive disease after prior therapy with crizotinib OR member will be using as subsequent therapy for BRAF V600E positive disease OR The member will be using as subsequent therapy after pembrolizumab and EGFR, ALK, BRAF V600E, and ROS-1 negative disease OR member has metastatic NSCLC, non- squamous histology with no EGFR or ALK genomic tumor aberrations AND Abraxane will be given combo with Tecentriq and carboplatin as first line therapy.				paclitaxel) as monotherapy AND The member will be using Abraxane (nab-paclitaxel) as second-line or subsequent therapy after progression on BRAF targeted therapy AND The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol) or the member has a documented contraindication to standard hypersensitivity premedications.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ACTHAR			Diagnostic testing of adrenocortical function: Contraindication or intolerance to cosyntropin. West syndrome (infantile spasms), Acute exacerbations of multiple sclerosis (MS) and other steroid responsive conditions: Member must be experiencing an acute exacerbation of multiple sclerosis or other disease exacerbation. Member has contraindications or intolerance to corticosteroids that are not expected to also occur with repository corticotropin injection. Reauthorization Criteria: There is documented evidence of disease response to treatment as indicated by improvement in symptoms.		Licensed Practitioner	MS Initial Auth 6 months, MS Reauth 6 months, All Other Indications 6 months.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ACTIMMUNE			Chronic Granulomatous Disease (CGD): The member has chronic granulomatous disease (CGD). The member is using Actimmune to reduce the frequency and severity of infections. Severe Malignant Osteopetrosis: The member has severe malignant osteopetrosis confirmed by biopsy. The member is using Actimmune to delay time to disease progression.		Licensed Practitioner	Plan Year	
ACYCLOVIR			The member must have a diagnosis of genital herpes OR member has a diagnosis of non-life-threatening mucocutaneous Herpes Simplex Virus (HSV) infection and is immunocompromised. The member has had previous treatment, contraindication, or intolerance with oral acyclovir and one of the following: valacyclovir or famciclovir.		Licensed Practitioner	Plan year duration	
ADCETRIS		Members that have experienced disease progression while on Adcetris.	Hodgkin lymphoma. Diagnosis of relapsed or refractory Hodgkin lymphoma. The member has documented evidence of progression following an autologous stem cell transplant OR is not a candidate for an autologous stem cell transplant but		Licensed Practitioner	6 months duration	Primary Cutaneous Anaplastic Large Cell Lymphoma (pcALCL) or CD30-expressing Mycosis Fungoides (MF). The member has a diagnosis of primary cutaneous anaplastic

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			documented evidence of progression on at least two previous multi-agent chemotherapy regimens OR the member will be using Adcetris (brentuximab) as palliative therapy for older adults (age greater than 60). The member will be using Adcetris as monotherapy or in combination with bendamustine. Systemic Anaplastic Large Cell Lymphoma (sALCL). Diagnosis of relapsed or refractory systemic anaplastic large cell lymphoma. The member has documented evidence of progression on at least one prior multi-agent chemotherapy regimen The member will be using Adcetris (brentuximab vedotin) as monotherapy.Disease has confirmed CD30 positivity. Hodgkin Lymphoma Post-auto-HSCT Consolidation: The member has a diagnosis of classical Hodgkin lymphoma AND The member will be using Adcetris (brentuximab vedotin) as post-autologous hematopoietic stem cell transplant (HSCT) consolidation AND The member is at high risk of post-autologous				large cell lymphoma (pcALCL) or CD30-expressing mycosis fungoides (MF) AND The member has received at least one prior systemic therapy AND The member will be using Adcetris (brentuximab vedotin) as monotherapy.

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			HSCT relapse or progression (must meet at least one of the following criteria): Refractory disease to front-line therapy, Relapsed disease within 12 months to front-line therapy, Relapsed disease with extranodal disease to front-line therapy. Previously untreated Hodgkin lymphoma. The member has a diagnosis of stage III or IV classical Hodgkin lymphoma AND The member has previously untreated disease AND The member will be using Adcetris (brentuximab vedotin) in combination with doxorubicin, vinblastine, and dacarbazine.				

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ADEMPAS		Concurrent use with nitrates or nitric oxide donors in any form. Concurrent use with specific PDE5 inhibitors such as sildenafil, tadalafil, vardenafil and non-specific PDE inhibitors such as dipyridamole or theophylline.	Chronic Thromboembolic Pulmonary Hypertension (CTEPH). The member must have a diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) AND The member must have CTEPH classified as inoperable or persistent/recurrent after surgical treatment (i.e. pulmonary endarterectomy). Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADVANCED GLUC METER TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ADVANCED GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

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ADVATE					Licensed Practitioner	Plan Year Duration	
ADVOCATE BLOOD GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADVOCATE DUO			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ADVOCATE DUO METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADVOCATE REDI-CODE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ADVOCATE REDI-CODE DUO METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADVOCATE REDI-CODE GLU MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ADVOCATE REDI-CODE PLUS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADVOCATE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ADYNOVATE					Licensed Practitioner	Plan Year Duration	
AFINITOR		Members that have experienced disease progression while on everolimus.	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV) AND the member experienced intolerance on Inlyta (axitinib) or Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe	TSC associated partial onset seizures: Member is 2 years of age or older.	Licensed Practitioner	6 months duration	Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human

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			hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome) AND Afinitor (everolimus) is given as monotherapy or being given in combination with Lenvima (lenvatinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstrom's macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary				epidermal growth factor receptor 2-negative metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) within one year AND The member will use Afinitor (everolimus) in combination with exemestane or fulvestrant (Faslodex). Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC-associated partial onset seizures AND Afinitor Disperz (everolimus tablets for oral solution) is being used as adjunctive therapy.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatment or relapsed Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.				
AFINITOR DISPERZ		Members that have experienced disease progression while on everolimus.	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV) AND the member experienced intolerance on Inlyta (axitinib) or Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome) AND Afinitor (everolimus) is given as monotherapy or being given in combination with Lenvima (lenvatinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis	TSC associated partial onset seizures: Member is 2 years of age or older.	Licensed Practitioner	6 months duration	Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) within one year AND The member will use Afinitor (everolimus) in combination with

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			AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstrom's macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.				exemestane or fulvestrant (Faslodex). Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC-associated partial onset seizures AND Afinitor Disperz (everolimus tablets for oral solution) is being used as adjunctive therapy.
AFSTYLA					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AGAMATRIX AMP GLUC MONITOR SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
AGAMATRIX AMP TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AGAMATRIX PRESTO TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AIMOVIG AUTOINJECTOR			Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has had a sustained decrease of greater than or equal to 3 migraine days per month OR the member has had a sustained greater than or equal to 50% decrease in the number of monthly migraine days.	The member is 18 years of age or older.	Licensed Practitioner	Initial auth: 3 months. Reauth: Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AIMOVIG AUTOINJECTOR (2 PACK)			Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has had a sustained decrease of greater than or equal to 3 migraine days per month OR the member has had a sustained greater than or equal to 50% decrease in the number of monthly migraine days.	The member is 18 years of age or older.	Licensed Practitioner	Initial auth: 3 months. Reauth: Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ALECENSA		The member has experienced disease progression while on Alecensa (alectinib).	Non-small Cell Lung Cancer:The member has recurrent or metastatic non-small cell lung cancer AND The member has documented anaplastic lymphoma kinase (ALK)-positive disease AND The member will be using Alecensa (alectinib) as monotherapy AND The member will be using Alecensa (alectinib) as first-line therapy OR as subsequent therapy after progressive disease or intolerance following treatment with Xalkori (crizotinib).		Licensed Practitioner	Six months duration	
ALIMTA		Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute.	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma AND must be using pemetrexed as induction therapy in combination with cisplatin or carboplatin for medically operable clinical stage I-III OR must be using Alimta as a single agent or in combination with cisplatin or carboplatin OR is using Alimta as second-line as a single agent if not administered first-line. OR Alimta is being used in combination with bevacizumab product		Licensed Practitioner	6 months duration	Bladder Cancer. Diagnosis of metastatic bladder cancer AND Alimta (pemetrexed) is being used as second-line or subsequent therapy as a single agent for metastatic disease. Cervical Cancer. Diagnosis of cervical cancer AND Alimta (pemetrexed) is being used as a second-line or subsequent therapy as a single agent for local/regional

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			and cisplatin. Non-Small Cell Lung Cancer (Nonsquamous). Diagnosis of nonsquamous NSCLC that is locally advanced or metastatic AND one of the following applies: Alimta is being used in combination with cisplatin or carboplatin therapy for the initial treatment in members with a performance status (PS) 0-2 or Alimta is being used in cisplatin or carboplatin-based regimens in combination with bevacizumab product in members with PS 0-1 and no history of hemoptysis or as a single agent in PS 2 or as a single agent after prior chemotherapy. OR Alimta is being used as a single agent for the maintenance treatment of members whose disease has not progressed after four cycles of platinum-based first-line chemotherapy OR As a single agent for recurrence or metastasis in members who achieved tumor response or stable disease following first-line chemotherapy with Alimta OR in combination with Keytruda and carboplatin or cisplatin as first line				recurrence or distant metastases. Ovarian Cancer. Diagnosis of Ovarian Cancer, or Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer AND Alimta (pemetrexed) is being used as a single agent for persistent disease or recurrence therapy. Thymic Malignancy. Diagnosis of thymic malignancy AND Alimta (pemetrexed) is being used as second-line therapy as a single agent.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapy for nonsquamous metastatic NSCLC followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed OR in combination with cisplatin used as neoadjuvant or adjuvant chemotherapy OR Concurrent chemoradiation in combination with carboplatin or cisplatin.				
ALIQOPA		The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib)	Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND The member has relapsed, refractory, or progressive disease AND The member has received at least two prior systemic therapies AND The member will be using Aliqopa as monotherapy		Licensed Practitioner	6 month duration	
ALPHANATE					Licensed Practitioner	Plan Year Duration	
ALPHANINE SD					Licensed Practitioner	Plan Year Duration	
ALPROLIX					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ALUNBRIG		Members on concomitant ALK inhibitors (e.g., Zykadia [certinib], Alecensa [alectinib]). Members experience disease progression on Alunbrig (brigatinib).	Non-Small cell lung cancer: The member has a diagnosis of advanced or metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Alunbrig will be given as monotherapy.		Licensed Practitioner	Six month duration	
ALYQ		Concurrent use of nitrates (e.g., nitroglycerin) OR Concurrent use of another PDE5 inhibitor, sildenafil (Revatio)	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan year duration	

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AMBRISENTAN		The patient is concomitantly taking endothelin receptor antagonist (e.g., Tracleer, Opsumit). Member has a diagnosis of idiopathic pulmonary fibrosis.	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan Year Duration	
AMITRIPTYLINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
APTIOM		Use of oxcarbazepine	Partial-Onset Seizures. Diagnosis of partial-onset seizures. Prior therapy with, contraindication, or intolerance to at least two other drugs for controlling partial-onset seizures (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Inadequately controlled seizures.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ARALAST NP		IgA deficient members or presence of antibodies against IgA.	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ARCALYST			Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome: The member has a diagnosis of Cryopryin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS).	Member must be 12 years of age or older.	Licensed Practitioner	Plan Year Duration	
ARSENIC TRIOXIDE			Acute Promyelocytic Leukemia (APL). The member has a diagnosis of acute promyelocytic leukemia AND the member will be using Trisenox (arsenic trioxide) for induction therapy, consolidation therapy, or relapsed disease.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ARZERRA			Arzerra/ofatumumab will require prior authorization. For new starts only.This agent may be considered medically necessary when the following criteria are met:The patient has a diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL).Chronic Lymphocytic Leukemia (CLL) Previously Untreated: The member has a diagnosis of chronic lymphocytic leukemia AND The member has not previously received treatment for CLL AND one of the following applies: The member may use in combination with chlorambucil when fludarabine-based therapy is not appropriate OR the member will be using in combination with bendamustine. CLL: Chronic Lymphocytic Leukemia, Extended Treatment:The member has a diagnosis of recurrent or progressive chronic lymphocytic leukemia AND The member is in complete or partial response after at least two lines of therapy.		Licensed Practitioner	6 months duration	
ASPARLAS		Members that	Acute Lymphoblastic Leukemia (ALL): The	The age of the	Licensed	6 Months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		have experienced disease progression while on or following Asparlas (calaspargase pegol-mknl). Members with a history of serious thrombosis with prior asparaginase therapy. Members with a history of pancreatitis with prior asparaginase therapy. Members with a history of serious hemorrhagic events with prior asparaginase therapy. Members with total bilirubin more than 10 times the upper	member has a diagnosis of acute lymphoblastic leukemia (ALL) AND The member will be using Asparlas (calaspargase pegol-mknl) as a component of a multi-agent chemotherapy regimen.	member is less than 21 years.	Practitioner	Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		limit of normal.					
ASSURE 4 STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ASSURE PLATINUM GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ASSURE PLATINUM TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ASSURE PRISM MULTI METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ASSURE PRISM MULTI STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
AUGMENTIN			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AURYXIA		Use for the treatment of iron deficiency anemia in chronic kidney disease not on dialysis without an approvable indication as set forth in the required medical information section.	Hyperphosphatemia associated with chronic kidney disease on dialysis. The member must have a diagnosis of hyperphospatemia associated with chronic kidney disease AND the member must be on dialysis.	Member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration	
AUSTEDO		Member is not actively suicidal. Member does not have untreated or inadequately treated depression. Member does not have severe hepatic impairment. Concomitant use	Tardive Dyskinesia. Initial Therapy. The member is utilizing Austedo (deutetrabenazine) for the treatment of tardive dyskinesia as seen by the following: The member has involuntary athetoid or choreiform movements AND The member has a history of treatment with dopamine receptor blocking agent AND. The member has moderate to severe tardive dyskinesia demonstrated by a score of 3 or 4 on item 8 (severity of abnormal movements overall) on the	Member is 18 years of age or older (Tardive Dyskinesia).	Licensed Practitioner	Initial auth: 3 months, Reauthorization: Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		of: Monoamine oxidase inhibitors: use with or within 14 days, Reserpine: use with or within 20 days, or Tetrabenazine or valbenazine.	Abnormal Involuntary Movement Scale (AIMS). Continuation Therapy. The member must show a documented overall reduction in their Abnormal Involuntary Movement Scale (AIMS) score (items 1 through 7) from baseline while on Austedo (deutetrabenazine) therapy. Chorea Associated with Huntington's Disease. Initial Therapy: The member must have a Diagnosis of chorea associated with Huntington's disease AND inadequate symptom control (e.g. no improvement in total maximal chorea (TMC) score, no improvement in overall motor function) on previous treatment with tetrabenazine or intolerance to tetrabenazine. Reauthorization: Member is not actively suicidal. Member does not have untreated or inadequately treated depression. Member does not have severe hepatic impairment. There is no concomitant use of: Monoamine oxidase inhibitors: use with or within 14 days, Reserpine: use with or within 20 days, or Tetrabenazine.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AVASTIN		Used in lung cancer members that have small cell or squamous cell disease, recent hemoptysis, history of bleeding, continuing anticoagulation, or as a single agent (unless maintenance as described in Coverage Determinations). Should not be initiated in members with recent hemoptysis. Should not be used in members who experience a severe arterial thromboembolic event. Should not	Metastatic colorectal cancer: metastatic colorectal cancer AND one of the following apply: using bevacizumab in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemotherapy for first or second-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line therapy in patients who have progressed on first-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology): NSCLC with non-squamous cell histology AND Member is using bevacizumab in combo with cisplatin or carboplatin based regimens for unresectable, locally advanced, recurrent, or metastatic NSCLC AND 1 of the following apply: using for 1st line therapy OR as subsequent therapy immediately after 1 of the following situations: EGFR mutation-positive tumors after prior therapy with erlotinib, afatinib, or gefitinib (if cytotoxic therapy not previously not		Licensed Practitioner	6 Months Duration	Metastatic breast cancer (Effectiveness based on improvement in progression-free survival. No data available demonstrating improvement in disease-related symptoms or survival with bevacizumab). Member has metastatic HER-2 negative breast cancer AND member is using bevacizumab in combination with paclitaxel. Recurrent Ovarian Cancer. Bevacizumab (if not previously administered) is being used to treat recurrent or persistent ovarian cancer for one of the following situations: in combo with liposomal doxorubicin or weekly paclitaxel or topotecan for platinum resistant disease or as monotherapy or in

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		be used in members with gastrointestinal perforation. Bevacizumab should not be used in members with fistula formation involving internal organs. Bevacizumab should not be used in members experiencing a hypertensive crisis or hypertensive encephalopathy. Bevacizumab should not be used for at least 28 days following major surgery or until surgical incision is fully healed. Bevacizumab may	given) OR ALK-positive tumors after prior therapy with crizotinib or ceritinib, or alectinib or brigatinib (if cytotoxic therapy not previously not given) OR ROS-1 positive disease after prior therapy with crizotinib (if cytotoxic therapy not previously not given) OR Pembrolizumab (with PD-L1 expression of greater than 1%) administered as first line therapy and EGFR, ALK, BRAF V600E, and ROS1 negative tumors (if cytotoxic therapy not previously not given) OR has BRAF V600E positive disease OR using bevacizumab as single-agent continuation maintenance therapy if bevacizumab was used as 1st line treatment for recurrence or metastasis OR disease with no EGFR or ALK genomic tumor aberrations AND bevacizumab will be given in combo with carboplatin and paclitaxel and Tecentriq as 1st line therapy followed by maintenance therapy with combo Tecentriq and bevacizumab. Age Related Macular Degeneration. Diabetic Macular Edema. Hepatocellular carcinoma:				combination with carboplatin and gemcitabine for platinum sensitive disease. Stage IV/Metastatic (Unresectable) RCC. Member has RCC and member is using bevacizumab to treat stage IV unresectable kidney cancer in combination with interferon alpha OR member is using bevacizumab as systemic therapy for non-clear cell histology. Recurrent Primary CNS Tumor (including Glioblastoma multiforme).The member has a diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND Bevacizumab is being used as a single agent or in combination with irinotecan, carmustine, lomustine or temozolomide. The member does not have a CNS

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		not be used in conjunction with Vectibix. Bevacizumab may not be used in conjunction with Erbitux. Bevacizumab may not be used in the adjuvant or neoadjuvant setting. Bevacizumab should not be continued or restarted after disease progression with the exception of metastatic colorectal cancer.	unresectable or metastatic HCC AND used will be used as 1st line therapy in combo with Tecentriq.				hemorrhage. Soft Tissue Sarcoma. Diagnosis of angiosarcoma and bevacizumab is being used as a single agent OR has a diagnosis of solitary fibrous tumor and hemangiopericytoma and bevacizumab is being used in combo with temozolomide. Macular Retinal Edema. Bevacizumab is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: recurrent, or metastatic cervical cancer AND Bevacizumab will be used in combo (if not previously used as first line therapy) with paclitaxel and cisplatin or carboplatin and paclitaxel or paclitaxel and topotecan as first line therapy. Endometrial Cancer:

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							The member has progressive endometrial cancer AND Bevacizumab will be used as a single-agent. Malignant Pleural Mesothelioma. The member has a diagnosis of unresectable malignant pleural mesothelioma and bevacizumab will be used in combination with cisplatin and pemetrexed followed by bevacizumab as monotherapy for maintenance therapy (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND has Stage III or IV disease AND bevacizumab initially given in combo with carboplatin and paclitaxel after initial surgical resection followed by bevacizumab

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							monotherapy OR advanced epithelial ovarian, fallopian tube or primary peritoneal cancer AND disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation OR genomic instability as defined by FDA approved test AND Member is in complete response or partial response to 1st line treatment with platinum-based chemo AND Bevacizumab is given in combo with Lynparza.
AYVAKIT		Member experiences disease progression on Ayvakit (avapritinib).	Gastrointestinal Stromal tumor. The member has documented PDGFRA exon 18 mutation-positive unresectable or metastatic gastrointestinal stromal tumor (including PDGFRA D842V) AND Ayvakit (avapritinib) will be given as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AZACITIDINE		Concomitant use with hypomethylators (e.g. azacitidine, decitabine) . Applies to azacitidine only: the member must not have a diagnosis of advanced malignant hepatic tumors.	Myelodysplastic Syndromes.The member has a diagnosis of myelodysplastic syndrome AND For requests for decitabine, the member has contraindication to, intolerance to, or unable to achieve treatment goals with azacitidine AND one of the following scenarios apply: The member has a Revised International Prognostic Scoring System (IPSS-R) of higher risk disease (i.e. intermediate, high, very high) OR The member has a Revised International Prognostic Scoring System (IPSS-R) of lower risk disease (i.e. very low, low, or intermediate) AND one of the following sets of criteria applies: Clinically relevant thrombocytopenia, neutropenia, or increased marrow blasts OR Member has symptomatic anemia AND No 5q deletion AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND Serum erythropoietin levels		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			less than or equal to 500 mU/mL AND An inadequate response to erythropoietins alone or in combination with Revlimid (lenalidomide) AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND 5q deletion AND An inadequate response or intolerance to Revlimid (lenalidomide) AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia. Acute Myelogenous Leukemia (AML). The member has a diagnosis of AML.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AZEDRA DOSIMETRIC		Members on concomitant drugs that reduce catecholamine uptake or deplete catecholamine stores. Members with severe renal impairment (creatinine clearance less than 30 ml/min).	Pheochromocytoma: Member has a diagnosis of unresectable, locally advanced, or metastatic pheochromocytoma AND Member has imaging documenting positive iobenguane scan AND member has had an administration of inorganic iodine. Paraganglioma: Member has a diagnosis of unresectable, locally advanced, or metastatic paraganglioma AND Member has imaging documenting positive iobenguane scan AND member has had an administration of inorganic iodine administered 90 days apart.	12 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AZEDRA THERAPEUTIC		Members on concomitant drugs that reduce catecholamine uptake or deplete catecholamine stores. Members with severe renal impairment (creatinine clearance less than 30 ml/min).	Pheochromocytoma: Member has a diagnosis of unresectable, locally advanced, or metastatic pheochromocytoma AND Member has imaging documenting positive iobenguane scan AND member has had an administration of inorganic iodine. Paraganglioma: Member has a diagnosis of unresectable, locally advanced, or metastatic paraganglioma AND Member has imaging documenting positive iobenguane scan AND member has had an administration of inorganic iodine administered 90 days apart.	12 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BALVERSA			Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial carcinoma AND the member has identification of a susceptible FGFR3 or FGFR2 genetic alteration documented in the medical record [e.g., FGFR3 gene mutations (R284C, S249C, G370C, Y373C), FGFR gene fusions (FGFR3-TACC3, FGFR3-BAIAP2L1, FGFR2-BICC1, FGFR2-CASP7) AND the member will be using Balversa (erdafitinib) as a single agent for subsequent therapy after disease progression during or following at least one prior line of systemic therapy (i.e., platinum based chemotherapy or PD-1/PD-L1 therapy).		Licensed Practitioner	6 Months Duration	
BANZEL		Patients with familial short QT syndrome.	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND the member has prior therapy with, contraindication or intolerance to at least two other drugs indicated for LGS (e.g., topiramate, lamotrogine).	Member is one year of age or older.	Licensed Practitioner.	Plan Year Duration	
BAVENCIO		The member has	Merkel Cell Carcinoma (Adults). The	Pediatric Merkel Cell	Licensed	6 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		experienced disease progression on Bavencio (avelumab). The member has experienced disease progression while on or following PD-1/PD-L1 therapy (e.g Keytruda, Opdivo, Tecentriq, Imfinzi). The member has experienced disease progression while on or following Yervoy.	member has a diagnosis of metastatic Merkel cell carcinoma AND Member will be using Bavencio as monotherapy. Merkel Cell Carcinoma (Pediatrics). The member has a diagnosis of metastatic Merkel cell carcinoma AND Member will be using Bavencio as monotherapy. Urothelial Cancer. The member has a diagnosis of locally advanced or metastatic urothelial cancer AND the member will be using Bavencio (avelumab) as monotherapy AND One of the following apply: The member will be using Bavencio (avelumab) as second or subsequent line systemic therapy OR the member has had disease progression within 12 months of neoadjuvant or adjuvant chemotherapy OR The member will be using Bavencio (avelumab) as maintenance treatment if there is no disease progression with first-line platinum-containing chemotherapy. Renal Cell Carcinoma. The member has a diagnosis of advanced or metastatic renal cell carcinoma AND Bavencio (avelumab)	Carcinoma – member must be 12 years of age or older.	Practitioner	duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			will be given in combination with Inlyta (axitinib) as first-line therapy.				
BELEODAQ		Members that have experienced disease progression while on Beleodaq (belinostat). Members on concomitant Istodax (romidepsin), Zolinza (vorinostat), or Folotyn (pralatrexate) therapy.	Peripheral T-Cell Lymphoma (PTCL). The member must have a diagnosis of relapsed OR refractory peripheral T-cell lymphoma (PTCL).		Licensed Practitioner	six month duration	
BENDEKA		Members who experience disease progression on bendamustine containing regimens.	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL without del(17p)/TP53 mutation and with or without del(11q) AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a		Licensed Practitioner	6 months duration.	Waldenström's Macroglobulinemia:The member has Waldenström's macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma or nongastric MALT lymphoma and is using Bendamustine. The member has a diagnosis of mantle cell lymphoma and bendamustine is being used as one of the following: Less aggressive induction therapy OR Second-line therapy for relapsed, refractory or progressive disease. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with rituximab in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line				following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy .The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.				
BENEFIX					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BENLYSTA		Benlysta (belimumab) therapy is not considered medically necessary for members with the following concomitant conditions: severe active lupus nephritis, severe active central nervous system lupus, combination with other biologic products (examples include Humira, Enbrel, Remicade, Rituxan, Stelara, Cimzia, Kineret, Orencia, Simponi, Actemra), combination with cyclophosphamide	Benlysta (belimumab) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Systemic Lupus Erythematosus (SLE). The member must have a diagnosis of active systemic lupus erythematosus (SLE).The member must be auto-antibody positive in the absence of any drugs for SLE defined as: ANA titer greater than or equal 1:80 or anti-dsDNA level greater than or equal 30 I/mL.The member must be utilizing Benlysta (belimumab)in combination with standard treatment regimens for SLE which may include: corticosteroids (ex:prednisone), hydroxychloroquine, azathioprine.		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		.					
BENZTROPINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
BEOVU		Ocular or periocular infections. Active intraocular inflammation.	Neovascular (Wet) Age Related Macular Degeneration. The member is diagnosed with neovascular (wet) age-related macular degeneration AND The member has had prior therapy, contraindication, or intolerance to bevacizumab.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BESPONSA		Member has experienced disease progression while on or following Besponsa (inotuzumab ozogamicin)	Acute Lymphoblastic Leukemia: The member has a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL)AND The member has relapsed or refractory disease AND The member has documented CD22 blasts found in bone marrow or peripheral blood AND The member will be using Besponsa (inotuzumab ozogamicin) as monotherapy.		Licensed Practitioner.	Six month durations (up to a maximum of 6 cycles)	
BETASERON		Concomitant use with similar interferon products such as Avonex or Rebif.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BETHKIS		Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 80% predicted. Patients colonized with Burkholderia cepacia.	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa.	Must be 6 years of age or older.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BEXAROTENE		Members that are pregnant. Members on concomitant retinoid therapy.	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BIONIME RIGHTEST GM300 SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
BIONIME RIGHTEST TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BLENREP		The member has experienced disease progression on anti-BCMA-directed therapy.	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has relapsed/refractory disease AND The member has received at least four prior therapies, including an anti-CD38 monoclonal antibody (e.g. daratumumab), a proteasome inhibitor (e.g. bortezomib), and an immunomodulatory agent (e.g. lenalidomide) AND The member is using Blenrep (belantamab mafodotin-blmf) as a single agent.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BLINCYTO		The member is taking concomitant tyrosine kinase inhibitors (TKIs).	Relapsed or refractory B-cell acute lymphoblastic leukemia (ALL): The member has a diagnosis of Philadelphia chromosome-negative relapsed or refractory B-cell ALL OR The member has a diagnosis of Philadelphia chromosome-positive (Ph+) ALL that is refractory to tyrosine kinase inhibitor therapy (e.g. imatinib, dasatinib, ponatinib) AND Blincyto (blinatumomab) will be used as monotherapy. MRD-positive B-cell Precursor Acute Lymphoblastic Leukemia (ALL). The member has a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) AND The member is in either first or second complete remission AND The member has minimal residual disease (MRD).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BLOOD GLUCOSE MONITORING			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
BLOOD GLUCOSE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BLOOD-GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BORTEZOMIB		The member has experienced disease progression while on bortezomib.	Mantle Cell Lymphoma (MCL):The member has a diagnosis of Mantle Cell Lymphoma(MCL). Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib) is being used for primary therapy, therapy for previously treated disease that does not respond to primary therapy or progressive or relasped disease AND Velcade (bortezomib) is being used as monotherapy in combination with Dexamethasone or in combination with Rituxan (rituximab)		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BOSENTAN		The member is concomitantly taking cyclosporine-A or glyburide. The member is concomitantly taking endothelin receptor antagonist (e.g., Letairis, Opsumit).	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan year duration	
BOSULIF		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Bosulif (bosutinib).	Chronic Myelogenous Leukemia. The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR For members with newly diagnosed chronic phase CML, one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Low risk score for disease progression and has		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			contraindication to, intolerance to, or unable to achieve treatment goals with imatinib and Sprycel (dasatinib) OR Documented mutation of E255K/V, F317L/V/I/C, F359V/C/I, T315A, or Y253H OR For members with a diagnosis of chronic phase CML that has received previous treatment one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Documented mutation of E255K/V, F317L/V/I/C, F359V/C/I, T315A, or Y253H.				
BRAFTOVI		Members on concomitant Yervoy (ipilimumab), Opdivo	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating		Licensed Practitioner	Six month durations or as determined through	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic(cobimetinib), Tafinlar (dabrafenib), or Mekinist (trametinib) OR Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist	mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Colorectal Cancer - [Braftovi (encorafenib) requests only]: The member has documented BRAFV600E metastatic metastatic colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab).			clinical review	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(trametinib)].					
BREEZE 2 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BRINEURA		Acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection). Placement of ventriculoperitoneal shunts.	CLN2 Disease (Neuronal Ceroid Lipofuscinosis Type 2): The member must have a diagnosis of late infantile CLN2 disease (neuronal ceroid lipofuscinosis type 2) confirmed by tripeptidyl peptidase 1(TPP1)deficiency testing. The member must not have disease severity immediately prior to starting Brineura treatment as defined by a score of less than 3 in the CLN2 Clinical Rating Scale. Brineura will be administered by, or under the direction of a physician knowledgeable in intraventricular administration. Reauthorization Criterion: The member must not have disease progression while on Brineura treatment as defined by unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale at each 24 week treatment interval after the first 48 weeks of treatment.	The member must be at least 3 years of age and older.	Licensed Practitioner	Initial auth: 12 months. Reauth: 24 weeks.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BRIVIACT			Partial-onset seizures. Member must have a diagnosis of partial-onset seizures. Member has had prior therapy with levetiracetam AND one of the following: topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine.	Must be 4 years of age or older	Licensed Practitioner	Plan Year Duration	
BROVANA		Initiation during acute deteriorations of COPD.Concurrent use with other medications containing Long acting beta 2 (LABA). Asthma, in the absence of concurrent medication containing inhaled corticosteroid and cormorbid COPD diagnosis.	Maintenance treatment of bronchoconstriction in chronic obstructive pulmonary disease (COPD),including chronic bronchitis and emphysema. The member has a diagnosis of COPD. The member must have previous treatment with contraindication or intolerance with Perforomist (formoterol).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
BRUKINSA		The member has experienced disease progression while on or following a BTK inhibitor (e.g. ibrutinib, acalabrutinib, zanabrutinib).	Mantle cell lymphoma. The member has a diagnosis of mantle cell lymphoma AND The member has received at least one prior therapy AND The member will be using Brukinsa (zanabrutinib) as monotherapy.		Licensed Practitioner	Six month duration	
BUTALBITAL-ACETAMINOP-CAF-COD			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CABLIVI			Acquired Thrombotic Thrombocytopenic Purpura: Member has a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) AND member has achieved a normalized platelet count following plasma exchange (PEX) in combination with Cablivi (caplacizumab-yhdp) and immunosuppresive therapy (e.g. rituximab) during inpatient treatment of TTP. Reauthorization: member continues to have evidence of ongoing disease (e.g. suppressed or unstable ADAMTS13 levels) AND member is still currently receiving therapy AND member has had 2 or fewer recurrences while actively receiving Cablivi.	Member must be 18 years of age or older.	Licensed Practitioner	3 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CABOMETYX		Member experiences disease progression on cabozantinib.	Renal cell carcinoma:The member has advanced renal cell carcinoma AND the member will be using Cabomtyx (cabozanitinib) as monotherapy. Hepatocellular carcinoma. The member has a diagnosis of hepatocellular carcinoma AND The member has been previously treated with Nexavar (sorafenib) AND Cabometyx (cabozantinib) will be given as monotherapy.		Licensed Practitioner	Six months duration	
CALQUENCE		The member has experienced disease progression while on or following a BTK inhibitor (e.g. ibrutinib, acalabrutinib).	Mantle Cell Lymphoma: The member had a diagnosis of mantle cell lymphoma AND the member has received at least one prior therapy AND the member will be using Calquence (acalabrutinib) as monotherapy. Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL): member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).		Licensed Practitioner.	6 months duration.	
CAPECITABINE		Members with severe renal impairment	Colon/Colorectal Cancer.The member has a diagnosis of Stage II, Stage III or metastatic colorectal cancer (colon or		Licensed Practitioner	Plan Year Duration	Neuroendocrine Tumors of Pancreas. The member has unresectable locoregional

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(creatinine clearance less than 30mL/min).	rectal cancer). Breast Cancer.The member has a diagnosis of recurrent or metastatic breast cancer AND The member is using Xeloda (capecitabine) as a single agent or in combination with one of the following agents: trastuzumab product, Taxotere (docetaxel), Tykerb (lapatinib ditosylate) OR the member has metastatic or advanced breast cancer and all of the following apply: member has documented HER2 positive disease AND the member has received two or more prior anti-HER2 based regimens in the metastatic setting AND Nerlynx is given in combination with capecitabine OR The member has metastatic or advanced unresectable HER 2 positive breast cancer (inclusive of brain metastases) and all of the following apply: Member has received one or more prior anti-HER2 based regimen in the metastatic setting Capecitabine is given in combination with trastuzumab product and Tukysa (tucatinib) as subsequent therapy. Central Nervous System Cancer. The member has brain metastases				disease or distant metastatic disease and the member is experiencing with symptoms, clinically significant tumor burden, or significant progression and the member will be using Xeloda (capecitabine) in combination with Temodar (temozolomide). Ovarian Cancer. The member is using as single-agent therapy for persistense disease or recurrence.Pancreatic adenocarcinoma. The member has a diagnosis of pancreatic adenocarcinoma. Head and Neck Cancers:The member is using Xeloda (capecitabine) for recurrent, unresectable, or metastatic head and neck cancer. Anal Cancer. The member has a diagnosis of anal carcinoma and Xeloda (capecitabine) is

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			associated with primary tumor (breast) and one of the following conditions applies: Recurrent disease (limited disease), or Recurrent stable systemic disease (multiple lesions). Esophageal Cancer. The member has a diagnosis of cancer of the distal esophagus or gastroesophageal junction. Gastric Cancer. The member is using Xeloda (capecitabine) as therapy for locoregional or advanced/metastatic gastric cancer. Hepatobiliary Cancers. The member has a diagnosis of hepatobiliary cancer and Xeloda (capecitabine) will be used as single agent or in combination with gemcitabine, oxaliplatin, or cisplatin for one of the following conditions: Primary treatment for unresectable or metastatic disease or in concurrent chemoradiation.				being given in combination with mitomycin as concurrent chemoradiation.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CAPLYTA		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia. The member must have a diagnosis of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.	The member must be 18 years of age or older.		Plan Year Duration	
CAPRELSA		Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Vandetanib.	Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic medullary thyroid cancer AND The member has symptomatic or progressive disease OR the member has a diagnosis of symptomatic iodine refractory follicular carcinoma or Hurthle cell carcinoma or papillary carcinoma AND unresectable recurrent or persistent locoregional disease or metastatic disease.		Licensed Practitioner	3 months duration	
CARAC			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CARBAGLU			The member has acute or chronic hyperammonemia due to the deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS).		Licensed Practitioner	Plan Year Duration.	
CARESENS N			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CARESENS N TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CARESENS N VOICE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CARETOUCH GLUCOSE MONITORING			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CARETOUCH KETONE-GLUCOSE MONIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CARETOUCH TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CAYSTON		Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 75% predicted. Patients colonized with Burkholderia cepacia.	Cystic Fibrosis. The member must have a diagnosis of cystic fibrosis (CF). The member is colonized with Pseudomonas aeruginosa. The member must have a short or long-acting beta-agonist bronchodilator (e.g. albuterol or formoterol), and will be utilized prior to Cayston.	Must be 7 years of age or older.	Licensed Practitioner	Plan Year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CERDELGA		Concurrent use of a strong or moderate CYP2D6 inhibitor (eg. paroxetine, terbinafine) and a strong or moderate CYP3A inhibitor (eg. ketoconazole, fluconazole) in patients who are EMs or IMs.Concurrent use of a strong CYP3A inhibitor in patients who are IMs or PMs (eg. ketoconazole).	Type 1 Gaucher's disease:The member has a diagnosis of type 1 Gaucher's disease AND Member is a CYP2D6 poor metabolizer (PM), extensive metabolizer (EM), or intermediate metabolizer (IM) as confirmed by an FDA-approved genetic test.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CEREZYME			Cerezyme (imiglucerase) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Confirmed diagnosis of Type 1 Gaucher disease, resulting in one or more of the following conditions: Anemia, Thrombocytopenia, Bone disease, Hepatomegaly, Splenomegaly.		Licensed Practitioner	Plan Year Duration	
CHENODAL		A nonvisualizing gallbladder confirmed by two consecutive single doses of dye OR Radiopaque (calcified) stones OR Pregnancy OR Patients with known hepatocyte dysfunction OR Patients with biliary tract disease including bile ductal	The member has a diagnosis of radiolucent gallstones in well-opacifying gallbladders AND the member is not a candidate for laparoscopic cholecystectomy AND the member must have had previous treatment with, contraindication, or intolerance to ursodiol.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		abnormalities such as inrahepatic cholestasis, primary biliary cirrhosis, or sclerosing cholangitis OR Patients with gallstone complications or gallbladder disease necessitating surgery due to unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-GI fistula.					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CHOICEDM CLARUS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CHOLBAM			Bile acid synthesis disorders due to single enzyme defects initial review: The member must have a diagnosis of bile acid synthesis disorders (BASDs) due to single enzyme defects confirmed by Fast Atom Bombardment Ionization analysis (FAB-MS) (e.g. 3ß-hydroxy- ?5-C27-steroid oxidoreductase (3ß-HSD)deficiency, ?4-3-oxosteroid 5ß-reductase (AKR1D1) deficiency, cerebrotendinous xanthomatosis (CTX), or 2-[or a-] methylacyl-CoA racemase (AMACR) deficiency). Adjunctive treatment of		Licensed Practitioner	Initial authorization: 3 months. Continuation of Therapy: Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			peroxisomal disorders: The member must have a diagnosis of a peroxisomal disorder (PD) confirmed by Fast Atom Bombardment Ionization analysis (FAB-MS), including: Zellweger Syndrome or Neonatal Adrenoleukodystrophy or Generalized Peroxisomal Disorder or Refsum Disease or Peroxisomal disorder of unknown type) AND The member must have signs and symptoms of liver disease (e.g. jaundice, hepatomegaly, dark urine, discolored stools), steatorrhea or complications from decreased fat soluble vitamin absorption. Continuation of therapy: The member must show improvement in liver function within 3 months of the start of treatment without complete biliary obstruction: Alanine transaminase (ALT) or aspartate transaminase (AST) values reduced to less than 50 U/L or baseline levels reduced by 80% AND Total bilirubin values reduced to less than or equal to 1 mg/dL.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CHORIONIC GONADOTROPIN, HUMAN		Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.			Licensed Practitioner	Plan Year Duration	
CLEVER CHEK BLOOD GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLEVER CHEK BLOOD GLUCOSE SYST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CLEVER CHOICE BLOOD GLUC SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLEVER CHOICE GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CLEVER CHOICE MICRO			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLEVER CHOICE MICRO TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CLEVER CHOICE PRO			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLEVER CHOICE TALK GLUCOSE SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CLEVER CHOICE TALK TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLEVER CHOICE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CLEVER CHOICE VOICE+ TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLINDAGEL			Member has a diagnosis of acne vulgaris AND has had previous treatment or intolerance with two of the following topical products: adapalene 0.1% gel, clindamycin gel (generic Ceocin-T gel)/ lotion/solution or erythromycin pledgets/solution.		Licensed Practitioner	Plan Year Duration	
CLINDAMYCIN PHOSPHATE			Member has a diagnosis of acne vulgaris AND has had previous treatment or intolerance with two of the following topical products: adapalene 0.1% gel, clindamycin gel (generic Ceocin-T gel)/ lotion/solution or erythromycin pledgets/solution.		Licensed Practitioner	Plan Year Duration	
CLOBAZAM			Lennox-Gastaut Syndrome. Member has diagnosis of seizures associated with LGS.	Member is 2 years of age or older	Licensed Practitioner	Plan Year Duration	
CLOMIPRAMINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLOZAPINE		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had prior therapy or intolerance to generic clozapine.		Licensed Practitioner	Plan Year Duration	
COAGADEX					Licensed Practitioner	Plan Year Duration	
COMETRIQ		The member has experienced disease progression while on Cometriq (cabozantinib). Members on concomitant tyrosine kinase inhibitors.	Metastatic Medullary Thyroid Carcinoma. The member has a diagnosis of progressive, metastatic medullary thyroid carcinoma MTC.		Licensed Practitioner	six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CONTOUR METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CONTOUR NEXT EZ METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CONTOUR NEXT LINK			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CONTOUR NEXT LINK 2.4			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CONTOUR NEXT METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CONTOUR NEXT ONE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CONTOUR NEXT TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
CONTOUR TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CONTRAVE			Weight Management:Upon initiation of treatment with obesity medication, Body Mass Index (BMI) is at Least 30 kg/m2 (obese) OR 27 kg/m2 (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidemia, type 2 diabetes). Member will be evaluated by prescribing physician to determine if at least 5% of baseline body weight has been lost at 12 weeks and at least every 6 months thereafter for continued treatment with obesity medication.	18 years or older	Licensed Practitioner	Plan Year Duration	
CONTROL AST MONITORING SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
COOL BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
COOL GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
COPAXONE			The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	
COPIKTRA		The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib, duvelisib).	Chronic lymphocytic leukemia. The member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND the member has relapsed or refractory disease AND The member will be using Copiktra (duvelisib) as monotherapy. Follicular lymphoma. The member has a diagnosis of follicular lymphoma AND The member has relapsed or refractory disease after at least two prior therapies AND The member will be using Copiktra (duvelisib) as monotherapy.		Licensed Practitioner	6 months duration.	
CORIFACT					Licensed Practitioner	Plan Year Duration	
CORLANOR		Acute decompensated heart failure, Sick	Heart Failure:The member must have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		sinus syndrome, sinoatrial block or 3rd degree atrioventricular block unless a functioning demand pacemaker is present, Severe hepatic impairment, Heart rate maintained exclusively by pacemaker,Strong CYP3A4 inhibitors.	ventricular ejection fraction less than or equal to 35% AND The member must be in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute AND Documentation of blood pressure greater than or equal to 90/50 mmHg AND Documentation of previous treatment, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker (e.g., carvedilol 50 mg daily, metoprolol 200 mg daily, or bisoprolol 10 mg daily). Heart Failure (Pediatric Patients) - The member must have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 45% AND The member has been clinically stable for at least 4 weeks and on optimized medical therapy AND The member is in sinus rhythm AND The member is 6 to 12 months of age and has a resting heart rate of greater than or equal to 105 beats per minute OR The member is 1 to less than 3 years of age and has a resting heart rate of greater				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			than or equal to 95 beats per minute OR The member is 3 to less than 5 years of age and has a resting heart rate of greater than or equal to 75 beats per minute OR The member is greater than 5 years of age and has a resting heart rate of greater than or equal to 70 beats per minute.				
COSENTYX		Combination therapy with other biologics (e.g. Humira, Kevzara and Remicade).	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. acitretin, methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND The member has had prior therapy with or intolerance to a single DMARD (e.g.	Member must be 18 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active akylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).				
COSENTYX (2 SYRINGES)		Combination therapy with other biologics (e.g. Humira, Kevzara and Remicade).	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. acitretin,	Member must be 18 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active akylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).				
COSENTYX PEN		Combination therapy with other biologics (e.g. Humira, Kevzara and Remicade).	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. acitretin, methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active	Member must be 18 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			akylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).				
COSENTYX PEN (2 PENS)		Combination therapy with other biologics (e.g. Humira, Kevzara and Remicade).	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. acitretin, methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis:	Member must be 18 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active akylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			ibuprofen, meloxicam, naproxen).				
COTELLIC		Members on Cotellic as a single agent.Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda(pembrolizumab), Tafinlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Cotellic. Members that	Melanoma: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Cotellic (cobimetinib) in combination with Zelboraf(vemurafenib).		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CRESEMBA		Familial short QT syndrome. Coadministration with strong CYP3A4 inhibitors, such as ketoconazole or high dose ritonavir. Coadministration with strong CYP3A4 inducers, such as rifampin, carbamazepine, St.John's wort, or long acting barbiturates.	Invasive Aspergillosis and Invasive Mucormycosis: Member must have diagnosis of invasive aspergillosis or invasive mucormycosis.		Licensed Practitioner	plan year duration	
CRYSVITA		Oral phospate within one week of starting Crysvita (burosumab) therapy. Vitamin D analogs within one week or starting Crysvita therapy.	X-Linked Hypophosphatemia (XLH) – Initial approval: Member must have diagnosis of XLH supported by both of the following: Serum fibroblast growth factor 23 (FGF23) level greater than 30 pg/mL OR a positive PHEX test AND a reduction in the ratio of the maximum rate of tubular phosphate reabsorption to the glomerular filtration	XLH: Member must be 6 months of age or older. TIO: Member must be 2 years of age or older.	Licensed Practitioner	Initial auth: 4 months duration. Continuation of therapy: Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Serum phosphorus levels within or above normal range for age. Severe renal impairment or end stage renal disease.	rate (TmP/GFR). Member must have clinical signs and symptoms of XLH (e.g. rickets, growth impairment, musculoskeletal pain, fractures). Continuation of therapy: Member must have been previously treated with Crysvita (burosumab). Member has experienced improvement in serum phosphorous concentrations while on Crysvita therapy. Member has experienced a positive clinical response (e.g. reduction in musculoskeletal pain, improvement in skeletal deformities, reduction in fractures, linear growth). Tumor-Induced Osteomalacia (TIO) - Initial Approval: The member must have a diagnosis of FGF23-related hypophosphatemia in tumor-induced osteomalacia supported by BOTH of the following: Serum fibroblast growth factor 23 (FGF23) level of greater than 30 pg/mL AND A reduction in the ratio of the maximum rate of tubular phosphate reabsorption to the glomerular filtration rate (TmP/GFR) AND The disease must be associated with phosphaturic			Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			mesenchymal tumors AND The disease cannot be curatively resected or localized AND The member must have clinical signs and symptoms of TIO (muscle weakness, skeletal weakness, muscle pain, fatigue, hypophosphatemia Tumor-Induced Osteomalacia (TIO) - Continuation of Therapy: The member must have been previously treated with Crysvita (burosumab) AND The member has experienced an increase in serum phosphorus from baseline while on Crysvita (burosumab) AND The member has experienced a positive clinical response (e.g. reduction in muscle weakness, muscle pain, fatigue, etc)				
CYCLOBENZAPRINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
CYRAMZA		Members that	Gastric Cancer: The member has a		Licensed	6 months	Hepatocellular Carcinoma:

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		have experienced disease progression while on Cyramza (ramuciruma).	diagnosis of advanced or metastatic gastric cancer or gastro-esophageal adenocarcinoma AND the member has disease progression or intolerance on or after prior therapy with platinum-based and/or fluoropyrimidine-based chemotherapy AND Cyramza (ramucirumab) will be used as subsequent therapy AND will be used as monotherapy or in combination with paclitaxel. Non-Small Cell Lung Cancer: member has a diagnosis of metastatic non-small cell lung cancer AND The member has disease progression or intolerance on or following platinum-based chemotherapy AND For members with EGFR or ALK genomic aberrations, the member has disease progression on FDA-approved therapy for these aberrations AND will be used in combo with Docetaxel OR member has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations AND is given in combo with erlotinib as first line therapy. Colorectal Cancer: member has a		Practitioner	duration	The member has a diagnosis of metastatic or unresectable hepatocellular carcinoma AND the member has received prior treatment with Nexavar (sorafenib) AND the member has alpha feta protein greater than or equal to 400 ng/ml AND Cyramza (ramucirumab) will be given as a single agent as subsequent therapy.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of unresectable or metastatic colorectal cancer AND Primary treatment in combination with irinotecan or FOLFIRI (fluorouracil, leucovorin calcium, and irinotecan) for unresectable metachronuous metastases and previous treatment with FOLFOX (fluorouracil, leucovorin calcium, and oxaliplatin) or CapeOX (capecitabine, oxaliplatin) as adjuvant therapy has been given OR The member has disease progression on or after prior therapy with a bevacizumab product, oxaliplatin, and a fluoropyrimidine (e.g. 5-fluorouracil, capecitabine) AND Cyramza (ramucirumab) is given in combination with FOLFIRI (irinotecan, folinic acid,and 5-fluorouracil) or irinotecan as therapy after first progression of disease if irinotecan was not previously given. Esophageal Cancer: member has a diagnosis of unresectable locally advanced or metastatic or recurrent esophageal adenocarcinoma with an Eastern Cooperative Oncology Group (ECOG)				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			performance status 0-2 AND Cyramza (ramucirumab) will be used as second line therapy with or without paclitaxel.				
CYSTARAN			Cystinosis: The member has a diagnosis of cystinosis AND The member is using Cystaran (cysteamine ophthalmic solution) in the treatment of corneal cystine crystal accumulation.		Licensed Practitioner	Plan Year Duration	
DALFAMPRIDINE		History of seizure disorder. Moderate to severe renal impairment (CrCl less 50ml/min).	Multiple Sclerosis. Member must have a diagnosis of one of the four types of multiple sclerosis: Relapse Remitting or Primary Progressive or Secondary Progressive or Progressive Relapsing. Patient must be ambulatory. Initial timed 25-foot walk T25W test or another objective measure of gait that provides evidence of significant walking impairment related to multiple sclerosis. Reauthorization Criteria. Documentation of improvement in walking using the T25W test or another objective measure of gait.		Licensed Practitioner	6 month duration and then reauthorization at six months for plan year duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
DARIO BLOOD GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
DARIO BLOOD GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
DARZALEX		Disease progression while	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND The		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		taking Darzalex (daratumumab).	member will be using Darzalex (daratumumab) for newly diagnosed disease AND the member is ineligible for autologous stem cell transplant AND the member will be using Darzalex (daratumumab) in combination with bortezomib, melphalan, and prednisone OR the member will be using Darzalex in combination with lenalidomide and dexamethasone OR the member is eligible for autologous stem cell transplant AND the member will be using Darzalex in combination with bortezomib, thalidomide, and dexamethasone OR the member will be using Darzalex (daratumumab) for relapsed, progressive, or refractory disease in one of the following scenarios: The member will be using Darzalex (daratumumab) in combination with Pomalyst (pomalidomide) and dexamethasone AND the member has received at least two prior therapies, including lenalidomide and a proteasome inhibitor (e.g. bortezomib, carfilzomib, or ixazomib) OR				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			The member will be using Darzalex (daratumumab) in combination with Velcade (bortezomib) and dexamethasone OR The member will be using Darzalex (daratumumab) in combination with Revlimid (lenalidomide) and dexamethasone OR The member will be using Darzalex (daratumumab) as monotherapy and one of the following applies: The member has received at least three prior lines of therapy, which must have included a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide) OR The member is double-refractory to a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide).				
DARZALEX FASPRO		Disease progression while taking	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member will be using Darzalex		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		daratumumab.	(daratumumab) Faspro for newly diagnosed disease AND the member is ineligible for autologous stem cell transplant AND the member will be using Darzalex Faspro in combination with bortezomib, melphalan, and prednisone OR the member will be using Darzalex Faspro in combination with lenalidomide and dexamethasone OR the member will be using Darzalex Faspro for relapsed or progressive disease in one of the following scenarios: in combination with Velcade (bortezomib) and dexamethasone OR in combination with Revlimid (lenalidomide) and dexamethasone OR as monotherapy and one of the following applies: The member has received at least three prior lines of therapy, which must have included a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide) OR The member is double-refractory to a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide).				
DAURISMO		The member has experienced disease progression while on Daurismo (glasdegib).	Acute Myeloid Leukemia. The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND One of the following applies: The member is age 75 years or older OR The member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. severe cardiac disease, baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2, or baseline serum creatinine greater than 1.3 mg/dL) AND The member will be using Daurismo (glasdegib) in combination with low-dose Cytarabine. Acute Myeloid Leukemia - Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member will be using Daurismo (glasdegib) as a component of repeating the initial successful induction regimen, if late		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			relapse (relapse occurring later than 12 months) AND Daurismo (glasdegib) has not been administered continuously AND Daurismo (glasdegib) was not stopped due to the development of clinical resistance.				
DECITABINE		Concomitant use with hypomethylators (e.g. azacitidine, decitabine) . Applies to azacitidine only: the member must not have a diagnosis of advanced malignant hepatic tumors.	Myelodysplastic Syndromes.The member has a diagnosis of myelodysplastic syndrome AND For requests for decitabine, the member has contraindication to, intolerance to, or unable to achieve treatment goals with azacitidine AND one of the following scenarios apply: The member has a Revised International Prognostic Scoring System (IPSS-R) of higher risk disease (i.e. intermediate, high, very high) OR The member has a Revised International Prognostic Scoring System (IPSS-R) of lower risk disease (i.e. very low, low, or intermediate) AND one of the following sets of criteria applies: Clinically relevant thrombocytopenia, neutropenia, or increased marrow blasts OR Member has		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			symptomatic anemia AND No 5q deletion AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND Serum erythropoietin levels less than or equal to 500 mU/mL AND An inadequate response to erythropoietins alone or in combination with Revlimid (lenalidomide) AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND 5q deletion AND An inadequate response or intolerance to Revlimid (lenalidomide) AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia. Acute				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Myelogenous Leukemia (AML). The member has a diagnosis of AML.				
DESIPRAMINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
DIATRUE PLUS BLOOD GLUCOSE MET			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
DIATRUE PLUS TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
DICLOFENAC EPOLAMINE			Topical treatment of acute pain due to minor strains, sprains, and contusions. The patient has a documented symptomatic acute pain condition. The member has a trial, intolerance or conraindication to two prescription strength nonsteroidal anti-inflammatory analgesics (e.g. celecoxib, meloxicam, diclofenac sodium, or naproxen) one of which must be meloxicam.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
DICLOFENAC SODIUM			Actinic Keratosis:The member has a diagnosis of actinic keratosis.The member has trial,intolerance, or contraindication to generic imiquimod 5% cream AND topical fluorouracil.		Licensed Practitioner	Plan year duration	
DOJOLVI			Long-Chain Fatty Acid Oxidation Disorders: The member has a diagnosis of long-chain fatty acid disorders (e.g. Very Long-chain acylCoA Dehydrogenase [VLCAD] deficiency, Carnitine Palmitoyltransferase 2 [CPT2] deficiency, Mitochondrial Trifunctional Protein [TFP] Deficiency, Long-chain 3 hydroxyacylCoA Dehydrogenase [LCHAD] deficiency) AND Genetic and/or molecular testing has been performed to confirm diagnosis (e.g. positive for pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
DOXEPIN			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
DOXORUBICIN, PEG-LIPOSOMAL			Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer and one of the following applies: if platinum sensitive, in combination with carboplatin OR if platinum resistant, as a single agent or in combination with bevacizumab product, in patients who have not previously received bevacizumab product OR The member has a diagnosis ovarian cancer and Liposomal doxorubicin will be used in combination with carboplatin and one of the following applies: neoadjuvant treatment in members who are poor surgical candidates or low likelihood of optimal cytoreduction or adjuvant treatment or primary treatment in		Licensed Practitioner	6 months duration	Non-Hodgkin's lymphoma: The member has a diagnosis of T-Cell Leukemia or Lymphoma AND Liposomal doxorubicin is given in combination with gemcitabine and vinorelbine as second line or subsequent therapy and one of the following applies: non-responders for acute subtypes or prior to proceeding to transplant OR The member has diagnosis of diffuse large B cell lymphoma AND Liposomal doxorubicin is given in combination with

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			members with incomplete previous surgery or staging. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression after treatment with or intolerance to anthracycline based therapy. Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to anthracycline based therapy. Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy or the member is using Liposomal doxorubicn as first line therapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will				RCDOP (rituximab product, cyclophosphamide, vincristine and prednisone) in members with documented poor ventricular OR The member has a diagnosis of Mycosis Fungoides (MF)/Sezary Syndrome (SS) and liposomal doxorubicin is given and one of the following: primary treatment OR as combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant OR The member has a diagnosis of relapsed or refractory peripheral T-cell lymphoma (not otherwise specified or enteropathy associated Tcell lymphoma) AND Liposomal doxorubicin is given as subsequent therapy in combination therapy with gemcitabine and vinorelbine

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			be using liposomal doxorubicin in combination with Velcade.				prior to proceeding to transplant.
DRIZALMA SPRINKLE			Major Depressive Disorder, Generalized Anxiety Disorder, Diabetic Peripheral Neuropathic Pain, Chronic Musculoskeletal Pain, Fibromyalgia. The member has a diagnosis of Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Diabetic Peripheral Neuropathic Pain (DPNP), Chronic Musculoskeletal Pain, or Fibromyalgia (FM). The member has prior therapy, intolerance, or contraindication with venlafaxine (IR or ER) AND duloxetine.		Licensed Practitioner	Plan year duration	
DUAVEE		Abnormal uterine bleeding. Known or past history of breast cancer. Active or past history of venous thromboembolism (e.g. pulmonary embolism, deep	Treatment of moderate to severe vasomotor symptoms associated with menopause:Diagnosis of moderate to severe vasomotor symptoms associated with menopause AND The member must have had previous treatment, intolerance or contraindication to a SSRI [e.g. citalopram, fluoxetine, paroxetine hydrochloride] or venlafaxine. Prevention		Licensed practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		vein thrombosis). Known estrogen-dependent neoplasia. Active or past history of arterial thromboembolism (e.g. stroke and myocardial infarction). Duavee should not be used in members who are pregnant or lactating. Known hepatic impairment or liver disease. Known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders. Concurrent use with estrogens,	of osteoporosis: For the prevention of osteoporosis in a member who is postmenopausal AND the member must have had previous treatment, intolerance, or contraindication to either alendronate or Evista (raloxifene).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		progestins, or estrogen agonists/antagonists.					
DUPIXENT PEN		For asthma indication only: Not for the relief of acute bronchospasm or status asthmaticus.	Atopic Dermatitis. Initial Review: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, fluocinonide 0.05%, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (i.e. pimecrolimus cream, tacrolimus) Reauthorization: The member has had an improvement in atopic dermatitis symptoms which has been sustained.	Atopic dermatitis: The member must be 6 years of age or older. Chronic rhinosinusitis with nasal polyposis: The member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma. Initial Review: The member has a diagnosis of moderate-to-severe asthma AND The member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of: greater than or equal to 150 cells/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Reauthorization. Member is currently stable on therapy AND Member will continue on asthma controller inhalers: inhaled corticosteroid with a long-acting beta2-agonist (e.g. Flovent HFA/Diskus, Arnuity Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicort HFA). Chronic Rhinosinusitis with Nasal Polyposis. Initial Review: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Reauthorization: The member has had an improvement in symptoms (e.g. decrease in nasal congestion, decrease in polyp size, improvement in ability to smell) which has been sustained AND Member will continue intranasal corticosteroid spray therapy.
DUPIXENT SYRINGE		For asthma indication only: Not for the relief of acute bronchospasm or status asthmaticus.	Atopic Dermatitis. Initial Review: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had	Atopic dermatitis: The member must be 6 years of age or older. Chronic rhinosinusitis with nasal polyposis: The member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma. Initial Review: The member has a diagnosis of moderate-to-severe asthma AND The member has an

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, fluocinonide 0.05%, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (i.e. pimecrolimus cream, tacrolimus) Reauthorization: The member has had an improvement in atopic dermatitis symptoms which has been sustained.				eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of: greater than or equal to 150 cells/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Reauthorization. Member is currently stable on therapy AND Member will continue on asthma controller inhalers: inhaled corticosteroid with a long-acting beta2-agonist (e.g. Flovent HFA/Diskus, Arnuity

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicort HFA). Chronic Rhinosinusitis with Nasal Polyposis. Initial Review: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Reauthorization: The member has had an improvement in symptoms (e.g. decrease in nasal congestion, decrease in polyp size, improvement in ability to smell) which has

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							been sustained AND Member will continue intranasal corticosteroid spray therapy.
DUROLANE			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
EASY GLUCO G2			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY PLUS II BLOOD GLUCOSE MET			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY PLUS II TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY STEP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY STEP BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY TALK BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY TALK GLUCOSE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY TOUCH GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY TOUCH TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY TRAK BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY TRAK GLUCOSE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASY TRAK II TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASY-TOUCH BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASYGLUCO METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASYGLUCO MONITORING SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASYGLUCO PLUS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASYGLUCO TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASYMAX			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASYMAX 15 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASYMAX L BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASYMAX NG			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EASYMAX V SPEAKING GLUCOSE SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EASYMAX V2 BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EGRIFTA		Egrifta (tesamorelin) therapy is not considered medically necessary for members with the following concomitant conditions: The member must not have an active malignancy. Pregnancy.	Egrifta (tesamorelin) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EGRIFTA SV		Egrifta (tesamorelin) therapy is not considered medically necessary for members with the following concomitant conditions: The member must not have an active malignancy. Pregnancy.	Egrifta (tesamorelin) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).		Licensed Practitioner	Plan Year	
ELELYSO			Gaucher Disease. The member has a confirmed diagnosis of Type 1 Gaucher disease.		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELEMENT COMPACT GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ELEMENT COMPACT TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELEMENT COMPACT V GLUCOSE MTR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ELEMENT PLUS BLOOD GLUCOSE KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELEMENT TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ELIGARD		Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Invasive Breast Cancer. The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer. The patient must be pre or perimenopausal. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELIGARD (3 MONTH)		Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Invasive Breast Cancer. The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer. The patient must be pre or perimenopausal. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration	
ELIGARD (4 MONTH)		Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Invasive Breast Cancer. The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer. The patient must be pre or perimenopausal. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELIGARD (6 MONTH)		Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Invasive Breast Cancer. The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer. The patient must be pre or perimenopausal. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration	
ELOCTATE					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELZONRIS		The member has disease progression while on Elzonris (tagraxofusp-erzs). The member has documented active central nervous system involvement by blastic plasmacytoid dendritic cell neoplasm (BPDCN).	Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN): The member has a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) according to World Health Organization (WHO) classification AND the member is able to be an inpatient for at least the first complete course of therapy plus an additional 24 hours for observation. Reauthorization Criteria: The provider attests that the member has received ongoing clinical benefit and has not experienced unacceptable toxicities.	The member must be 2 years of age or older.	Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMBRACE BLOOD GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EMBRACE BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMBRACE EVO BLOOD GLUCOSE KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EMBRACE EVO TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMBRACE PRO GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EMBRACE PRO TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMBRACE TALK BLOOD GLUCOSE SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EMBRACE TALK GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMBRACE TALK TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMGALITY PEN			Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has had a sustained decrease of greater than or equal to 3 migraine days per month OR the member has had a sustained greater than or equal to 50% decrease in the number of monthly migraine days.	The member is 18 years of age or older	Licensed Practitioner	Initial auth: 3 months. Reauth: Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMGALITY SYRINGE			Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has had a sustained decrease of greater than or equal to 3 migraine days per month OR the member has had a sustained greater than or equal to 50% decrease in the number of monthly migraine days.	The member is 18 years of age or older	Licensed Practitioner	Initial auth: 3 months. Reauth: Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EMPLICITI		Members with disease progression while on Empliciti (elotuzumab)	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND One of the following scenarios apply: The member has disease progression after receiving one to three prior lines of therapy AND Empliciti (elotuzumab) will be given in combination with lenalidomide (Revlimid) and dexamethasone OR in combination with bortezomib (Velcade) and dexamethasone OR The member has disease progression after receiving at least two prior therapies, including lenalidomide and a proteasome inhibitor AND Empliciti (elotuzumab) will be given in combination with pomalidomide (Pomalyst) and dexamethasone.		Licensed Practitioner	Six month duration	
ENBREL		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade).	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis:	Juvenile Idiopathic Arthritis.			

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.				
ENBREL MINI		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade).	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy,	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.				
ENBREL SURECLICK		Combination therapy with other biologics (e.g.	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy,	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Cosentyx, Enbrel, Humira, Kevzara, Remicade).	contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy	arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis.			

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.				
ENHERTU			Breast cancer: The member has a diagnosis of unresectable or metastatic breast cancer AND The disease is human epidermal growth factor receptor 2 (HER2) positive AND The member has received two or more prior anti-HER2 based regimens [e.g., Perjeta (pertuzumab)- based regimens, Kadcyla (ado-trastuzumab emtansine)] in the metastatic setting AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ENVARSUS XR			Member must have had a kidney transplant AND Must be using Envarsus XR for prophylaxis of organ rejection AND Must be using in combination with other immunosuppressants.		Licensed Practitioner	Plan Year Duration	
EPCLUSA			Chronic Hepatitis C Virus Genotypes: The member must have a diagnosis of chronic hepatitis C (HCV). The member must have HCV genotype documented prior to therapy. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.	6 years of age or older OR weigh at least 37 pounds (17 kilograms).	Licensed Practitioner.	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	
EPIDIOLEX			Dravet Syndrome. The member has a confirmed diagnosis of Dravet Syndrome by a specialist (i.e. neurologist, epileptologist) AND The member is taking at least 1 concomitant antiepileptic medication AND The member is refractory	The member is at least 1 year of age or older	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			on current therapy (e.g. has experienced a convulsive seizure in the past 28 days, i.e tonic, clonic, tonic-clonic, atonic). Lennox-Gastaut Syndrome. The member has a confirmed diagnosis of Lennox-Gastaut Syndrome by a specialist (i.e. neurologist, epileptologist) AND The member has an EEG which has shown a pattern of slow (less than 2.5 Hz) spike-andwave complexes AND The member is taking at least 1 concomitant antiepileptic medication AND The member is refractory on current therapy (e.g. has experienced a drop seizure in the past 28 days, i.e. tonic, atonic, tonic-clonic, that led to or could have led to a fall or injury). Reauthorization (all indications). The member has experienced an improvement in seizure frequency from documented pre-treatment baseline. Tuberous Sclerosis Complex: The member has a diagnosis of seizures associated with Tuberous Sclerosis Complex				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EPOPROSTENOL (GLYCINE)		Heart failure caused by reduced left ventricular ejection fraction.	Pulmonary Arterial Hypertension (PAH). Higher Risk: Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Member has WHO/NYHA Functional Class IV symptoms or is classified as high risk. Determinants of high risk include: Clinical evidence of RV failure, Rapid progression of symptoms, Shorter 6MW distance (less than300m), Peak VO2 less than 10.4 mL/kg/min for CPET, Pericardial effusion, significant RV enlargement/dysfunction, or right atrial enlargement on echocardiography, RAP greater than 20mmHg, CI less than 2.0 L/min/m2 and/or Significantly elevated BNP. Lower Risk: Member diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization with WHO/NYHA Functional Class II or III symptoms. AND member must have had prior therapy, intolerance or contraindication to an ERA (e.g. Tracleer, Letairis, Opsumit), AND either a PDE5 inhibitor (e.g. sildenafil,		Licensed Practitioner	Plan Year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			tadalafil) OR Adempas (riociguat).				
ERBITUX		Metastatic colorectal cancer patients with RAS mutations should not receive cetuximab due to known lack of response and possible worse outcomes in this population. Member has disease progression on Vectibix or Erbutux.Erbitux may not be used in conjunction with Vectibix, Tarceva or Iressa (all are EGFR inhibitors). Erbitux may not be used in	Metastatic Colorectal Cancer (mCRC). Diagnosis of Metastatic (stage IV) Colorectal Cancer.The member has mCRC that expresses verified wild-type (normal) KRAS/NRAS. Applies to new starts only.Erbitux (cetuximab) may be used as one of the following: monotherapy in mCRC members intolerant to irinotecan or who have experienced disease progression following therapy with both irinotecan and oxaliplatin based therapy OR combination with irinotecan-based therapy or with fluorouracil based therapy (e.g. FOLFOX, FOLFIRI) OR as subsequent therapy in combination with irinotecan and Zelboraf (vemurafenib) for progression of unresectable advanced or metastatic BRAF V600E mutation positive disease OR member experiences progressive disease on prior therapy and Erbitux is in combination with Braftovi for documented BRAFV600E mCRC. Head and Neck Cancer. Diagnosis of locally or		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		conjunction with Avastin.	regionally squamous cell advanced Head and Neck Cancer with concomitant XRT OR The member has recurrent or metastatic squamous cell Head and Neck Cancer and is receiving Erbitux (cetuximab) monotherapy after experiencing disease progression following platinum based therapy (may also be used in conjunction with a platinum agent).OR The member has advanced or recurrent squamous cell Head and Neck Cancer that is unresectable or the member is unfit for surgery OR The member has a diagnosis of recurrent locoregional disease or metastatic squamous cell carcinoma of the head and neck AND The member is receiving Erbitux (cetuximab) in combination with platinum-based therapy with 5-Fluorouracil.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ERIVEDGE		Erivedge (vismodegib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Erivedge (vismodegib). Members that are using Erivedge (vismodegib) as neoadjuvant therapy.	Advanced Basal Cell Carcinoma.The member has a diagnosis of metastatic basal cell carcinoma OR The member has a diagnosis of locally advanced basal cell carcinoma AND one of the following applies: The member has disease that has recurred following surgery OR the member is not a candidate for surgery AND radiation.		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ERLEADA		Members that have experienced disease progression while on Erleada (apalutamide). Concoitant use with an androgen receptor inhibitor or androgen synthesis inhibitor (e.g., enzulutamide, abiraterone, nilutamide, flutamide, bicalutamide) due to lack of evidence supporting efficacy and safety.	Prostate Cancer (non-metastatic castration resistant): The member has a diagnosis of non-metastatic castration resistant prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog). Prostate Cancer (metastatic castration-sensitive): The member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog).		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ERLOTINIB		Members on concomitant tyrosine kinase inhibitors.	Pancreatic Cancer: The member has a diagnosis of unresectable, locally advanced or metastatic pancreatic cancer. AND erlotinib is being used in combination with Gemzar (gemcitabine).Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC AND all of the following apply: The member has known documented activated EGFR mutation (such as E19del in exon 19 or L858R in exon 21). Renal Cell Carcinoma: Diagnosis of relapsed or unresectable stage IV renal cell carcinoma with non clear histology and erlotinib will be used as monotherapy.		Licensed Practitioner	6 months duration	
ERWINAZE		Erwinaze (asparaginase Erwinia chrysanthemi) therapy is not considered medically necessary for members with the	Erwinaze (asparaginase Erwinia chrysanthemi) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Acute Lymphoblastic Leukemia (ALL).The member has a diagnosis of ALL. The member has documented, Grade 2 – 4 hypersensitivity (based on Common		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		following concomitant conditions:Members with a history of serious pancreatitis with prior asparaginase based therapy,Members with a history of serious thrombosis with prior asparaginase based therapy,Members with a history of serious hemorrhagic events with prior asparaginase based therapy,Members that have experienced disease	Terminology Toxicity Criteria) as a result of prior treatment with Oncaspar (pegaspargase).The member is using Erwinaze (asparaginase Erwinia chrysanthemi) as a component of a multi-agent chemotherapeutic regimen.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		progression while on asparaginase based therapy.					
ESBRIET		Clinically significant environmental exposure known to cause pulmonary fibrosis, including but not limited to drugs, asbestos, beryllium, radiation, and domestic birds (Esbriet requests only). Known explanation for interstitial lung disease, including but not limited to radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis,	Idiopathic Pulmonary Fibrosis (IPF): The member has a diagnosis of idiopathic pulmonary fibrosis confirmed by one of the following: High-resolution computed tomography (HRCT) scan is indicative of usual interstitial pneumonia (UIP) OR A surgical lung biopsy. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) - Ofev (nintedanib) Requests only: The member will be taking Ofev (nintedanib) for a diagnosis of SSc-ILD confirmed by one of the following: High Resolution Computed Tomography (HRCT) with evidence of fibrosis OR Lung Biopsy AND Member does not have a previous or planned hematopoietic stem cell transplant AND Member does not have a diagnosis of Pulmonary Arterial Hypertension (WHO Group 1) requiring parenteral therapy with epoprostenol or treprostinil AND Member is not currently		Licensed Practitioner	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, and cancer (Esbriet requests only).	pregnant. Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype - Ofev (nintedanib) requests only: The member will be taking Ofev (nintedanib) for the diagnosis of a chronic fibrosing interstitial lung disease [ILD] (e.g., Hypersensitivity pneumonitis, Autoimmune ILD, Rheumatoid arthritis-associated ILD [RA-ILD], Mixed Connective Tissue Disease-associated ILD, Idiopathic non-specific interstitial pneumonia, Unclassifiable Idiopathic Interstitial Pneumonia, Exposure-related ILDs, Sarcoidosis with Fibrosing ILD, or other chronic fibrosing ILDs) confirmed by one of the following: High Resolution Computer Tomography (HRCT) with evidence of fibrosis OR Lung Biopsy. Member has a progressive phenotype confirmed by one of the following: Has had a relative decline in FVC of at least 10% OR Worsening respiratory symptoms OR Increased extent of fibrotic change on HRCT. Member is not currently pregnant.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ESKATA		Seborrheic keratosis lesions are open or infected. Seborrheic keratosis lesions are within orbital rim. Seborrheic keratosis lesions are asymptomatic and will be removed for cosmetic purposes.	Approval will be given to all members using this agent for medically necessary, FDA approved or compendia supported, non-cosmetic uses including but not limited to the following: Treatment of raised seborrheic keratoses that are symptomatic (e.g. pain or severe itching due to friction trauma).		Licensed Practitioner	8 weeks duration	
ESPEROCT					Licensed Practitioner	Plan Year Duration	
EUFLEXXA			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVENCARE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EVENCARE G2			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVENCARE G3 GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EVENCARE G3 TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVENCARE MINI GLUCOSE TEST STR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EVENCARE MINI MONITOR SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVENCARE PROVIEW TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EVENCARE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVOLUTION BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EVOLUTION TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVOMELA			Multiple Myeloma:The member has a diagnosis of mutliple myeloma. The member is utilizing Evomela as:High-dose conditioning treatment prior to stem cell transplantation OR Palliative treatment in members for whom oral therapy is not appropriate. Systemic Light Chain Amyloidosis: The member has a diagnosis of systemic light chain amyloidosis.The member will receive Evomela as:Primary treatment AND High-dose single-agent therapy with stem cell transplant.		Licensed Practitioner	six month durations	
EVRYSDI			Spinal Muscular Atrophy (SMA): The member has a diagnosis of Spinal Muscular Atrophy documented by SMN1 gene deletion OR 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote AND The member has a diagnosis of probable SMA type I, II, or III AND If symptomatic, symptom onset was evident prior to 18 years of age OR If asymptomatic, the member has no more than 4 copies of SMN2 AND The member is being treated	The member is 2 months of age or older.	Licensed Practitioner	Initial: 6 months. Continuation of therapy: 12 months.	Reauthorization: The member is responding to therapy, defined by an improvement or maintenance in motor milestones from predicted natural disease progression (e.g. head control, independent sitting, ability to kick in supine position, rolling, crawling) supported by functional assessment evaluation (e.g.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			by or in consultation with a specialist (e.g. neurologist) experienced in the management of SMA AND The member does not require permanent ventilation at time of administration (defined as requiring a tracheostomy or more than 21 consecutive days of either non-invasive ventilation greater than or equal to 16 hours per day or intubation, in the absence of an acute reversible event) AND Baseline functional assessment (e.g. Hammersmith Functional Motor Scale Expanded [HFMSE], Hammersmith Infant Neurological Examination [HINE], Upper Limb Module [ULM], Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], MFM32), based on age and motor ability, has been completed and submitted AND Genetic testing or lab and chart notes are submitted AND Risdiplam will NOT be used with other SMN2 directed therapies (e.g. nusinersen).				Hammersmith Functional Motor Scale Expanded [HFMSE], Hammersmith Infant Neurological Examination [HINE], Upper Limb Module [ULM], Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], MFM32) AND The member remains free of permanent ventilation (defined as requiring a tracheostomy or more than 21 consecutive days of either non-invasive ventilation greater than or equal to 16 hours per day or intubation, in the absence of an acute reversible event).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EXJADE		Patients on concomitant deferoxamine or deferipone. The member has platelet counts less 50,000.	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload.The patient has a diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions.For initial approval: Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment).For reauthorizations: Ferritin level must be consistently above 500mcg/L-deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L. Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L.		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EYLEA		Member has an active ocular or periocular infection, Member has active intraocular inflammation, Concurrent use with other VEGF inhibitors for intraocular use in the absence of documentation indicating that individual products are to be used in different eyes.	Age-Related Macular Degeneration. Member has a diagnosis of neovascular (wet) age-related macular degeneration AND member has had prior therapy, contraindication, or intolerance to bevacizumab. Macular Edema following Retinal Vein Occlusion (RVO). Member has a diagnosis of Macular Edema following Retinal Vein Occlusion (RVO) AND member had had prior therapy, contraindication, or intolerance to bevacizumab. Diabetic Macular Edema (DME) or Diabetic Retinopathy (DR). Member has a diagnosis of Diabetic Macular Edema or Diabetic Retinopathy AND member has had prior therapy, contraindication, or intolerance to bevacizumab. Prior treatment requirement does not apply for members with 20/50 or worse vision.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EZ SMART PLUS SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EZ SMART PLUS TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EZ SMART SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
EZ SMART TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FANAPT		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia. The member must be utilizing it for treatment of schizophrenia.The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.	The member must be 18 years or older.	Licensed Practitioner	Plan Year duration.	
FARYDAK		Disease progression on Farydak (panobinstat).	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND The member has received at least two prior regimens, including both bortezomib and an immunomodulatory drug (thalidomide, lenalidomide, pomalidomide) AND one of the following applies: The member will be using Farydak (panobinostat) in combination with bortezomib and dexamethasone OR the member will be using Farydak (panobinostat) in combination with Kyprolis (carfilzomib) OR the member will be using Farydak (panobinostat) in combination with Revlimid (lenalidomide) and dexamethasone.		Licensed Practitioner.	6 months duration.	
FASENRA PEN			Severe Asthma with an Eosinophilic		Licensed	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/µL at therapy initiation OR greater than or equal to 300 cells/µL in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Continuation of therapy: Member is currently stable on therapy. Member will continue on asthma controller inhalers: inhaled corticosteroids with or without a long-acting beta2-agonist (e.g. Flovent HFA/Diskus, Arnuity Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicort HFA). Eosinophilic Granulomatosis with Polyangiitis (EGPA): The member has a diagnosis of eosinophilic granulomatosis with		Practitioner	Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			polyangiitis (EGPA), defined by a baseline elevated peripheral blood eosinophil level of greater than 1000 cells/µL, a diagnosis of asthma, AND two or more systemic manifestations of EGPA. The member will be using Nucala (mepolizumab) for treatment of EGPA. The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone).				
FASLODEX		Member experiences disease progression on Faslodex.	Breast Cancer. The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression AND The member has a diagnosis of hormone receptor (HR)- positive metastatic breast cancer AND The member experienced disease progression, intolerance, or has a contraindication to endocrine therapy AND Faslodex (fulvestrant) is given as monotherapy OR The member has HR-positive and human epidermal growth factor receptor 2 negative breast cancer AND one of the following applies: The post-menopausal		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			member has not previously been treated with endocrine therapy for advanced disease and Faslodex (fulvestrant) will be used as monotherapy OR Faslodex (fulvestrant) is given in combination with Kisqali (ribociclib) as initial endocrine based therapy OR Faslodex (fulvestrant) is given in combination with Ibrance (palbociclib) or Verzenio (abemaciclib) or Kisqali (ribociclib) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) for their recurrent disease OR Faslodex (fulvestrant) is given in combination with Ibrance (palbociclib) or Verzenio (abemaciclib) or Kisqali (ribociclib) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) for their metastatic disease OR Faslodex (fulvestrant) is given in combination with Afinitor (everolimus) for disease that has been treated with endocrine therapy (e.g. letrozole, anastrazole) OR Faslodex (fulvestrant) is				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			given in combination with Piqray (alpelisib) for disease progression on or after endocrine based therapy (e.g. anstrazole, palbociclib) within one year of PIK3CA mutated disease.				
FEIBA NF					Licensed Practitioner	Plan Year Duration	
FENTANYL CITRATE		Treatment of acute or post-operative pain.	The member is currently diagnosed with cancer. Fentanyl citrate is required to manage breakthrough cancer pain. The member is currently taking opioid therapy and is opioid tolerant. Tolerance is defined as any of the following: greater than or equal 60 mg oral morphine/day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day for greater than or equal 1 week, An equianalgesic dose of another opioid for greater than or equal 1 week.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FETZIMA		Concurrent use with a MAOI or within 14 days of stopping or 7 days of starting a MAOI.	Major depressive disorder: The member must be utilizing it for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a serotonin and norepinephrine reuptake inhibitor (SNRI) AND a bupropion product (IR, SR, or XL) or mirtazapine.		Licensed Practitioner	Plan year duration	
FIFTY50 TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FINTEPLA		Treatment with a monoamine oxidase inhibitor within the last 14 days.	Dravet Syndrome: The member has a diagnosis of Dravet syndrome AND the member is experiencing seizures associated with Dravet syndrome on current therapy at baseline AND The member has had previous treatment with valproic acid AND fenfluramine will be taken concomitantly with another anti-epileptic supported for the treatment of seizures associated with Dravet Syndrome (e.g. valproic acid, clobazam, topiramate).	The member is 2 years of age or older.	Licensed Practitioner	Plan Year Duration	
FIRDAPSE		History of seizures (not to be inferred from pharmacy claims)	Lambert-Eaton Myasthenic Syndrome (LEMS). The member has a confirmed diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) by a specialist (e.g. neurologist) AND The diagnosis is supported by results from a clinical evaluation (e.g. electromyography or the presence of autoantibodies directed against VGCC {voltagegated calcium channels}). Member must have prior therapy, contraindication or intolerance to Ruzurgi.	The member is 18 years of age or older.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FIRMAGON		Concomitant use with other LHRH agents.	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.		Licensed Practitioner	Plan Year Duration	
FIRMAGON KIT W DILUENT SYRINGE		Concomitant use with other LHRH agents.	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.		Licensed Practitioner	Plan Year Duration	
FLECTOR			Topical treatment of acute pain due to minor strains, sprains, and contusions. The patient has a documented symptomatic acute pain condition. The member has a trial, intolerance or conraindication to two prescription strength nonsteroidal anti-inflammatory analgesics (e.g. celecoxib, meloxicam, diclofenac sodium, or naproxen) one of which must be meloxicam.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FOLOTYN		Members that have experienced disease progression while on pralatrexate.	Peripheral T-cell Lymphoma(PTCL):relapsed or refractory. Pralatrexate is being used to treat relapsed or refractory peripheral T-cell lymphoma (PTCL) (eg peripheral T-cell lymphoma, not otherwise specified: angioimmunoblastic T-cell lymphoma, anaplastic large cell lymphoma or enteropathy-associated T-cell lymphoma.		Licensed Practitioner	6 months	
FORA 6 CONNECT GLUCOSE STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA 6 CONNECT MULTIFUNCT N MTR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA D10			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA D15 GLUCOSE-BP MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA D15G STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA D20			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA D40-G31 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA D40D GLUCOSE-BP MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA D40G GLUCOSE-BP MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA G20			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA G30-PREMIUM V10 TEST STRP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA G30A			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA GD50 BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA GD50 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA GTEL GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA GTEL MULTI-FUNCTN MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA PREMIUM V10 GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA TEST N'GO VOICE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA TN'G VOICE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA TN'G VOICE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA V10			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA V10-V12-D10-D20 STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA V12 BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA V12 GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORA V20			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORA V30A			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORACARE GD20			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORACARE GD20 GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORACARE GD40 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORACARE GD40A GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORACARE GD40B GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORTEO			The member is postmenopausal with a diagnosis of osteoporosis. The member is at high risk for osteoporotic fracture as evident by one of the following: The member has a history of osteoporotic fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate, ibandronate, pamidronate). The member is taking sustained systemic glucocorticoid		Licensed Practitioner.	Plan year duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapy (daily dosage equivalent to 5 mg or greater of prednisone). The member is at high risk for osteoporotic fracture as evident by one of the following: The member has a history of osteoporotic fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate, ibrandronate, pamidronate). The member has a diagnosis of primary or hypogonadal osteoporosis, who is at high risk for fracture, defined as history of osteoporotic fracture, or who have multiple risk factors for fracture.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FORTISCARE BLOOD GLUCOSE SYST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FORTISCARE GLUCOSE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE FLASH SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE FREEDOM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE FREEDOM LITE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE INSULINX			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE INSULINX TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE LITE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE LITE STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE PRECISION NEO METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE PRECISION NEO STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE SIDEKICK II			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
FREESTYLE SYSTEM KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FREESTYLE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
FULPHILA		Concomitant use (within seven days	Febrile Neutropenia Prophylaxis. The member must have a diagnosis of non-		Licensed Practitioner	4 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		of Fulphila (pegfilgrastim-jmdb) dose) with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrastim, or sargramostim. Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once per chemotherapy	myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than 2.0 mg/dL) OR Renal dysfunction				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	(creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.				
FULVESTRANT		Member experiences disease progression on Faslodex.	Breast Cancer. The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression AND The member has a diagnosis of hormone receptor (HR)- positive metastatic breast cancer AND The member experienced disease progression, intolerance, or has a contraindication to endocrine therapy AND Faslodex (fulvestrant) is given as monotherapy OR The member has HR-positive and human epidermal growth factor receptor 2 negative breast cancer AND one of the		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			following applies: The post-menopausal member has not previously been treated with endocrine therapy for advanced disease and Faslodex (fulvestrant) will be used as monotherapy OR Faslodex (fulvestrant) is given in combination with Kisqali (ribociclib) as initial endocrine based therapy OR Faslodex (fulvestrant) is given in combination with Ibrance (palbociclib) or Verzenio (abemaciclib) or Kisqali (ribociclib) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) for their recurrent disease OR Faslodex (fulvestrant) is given in combination with Ibrance (palbociclib) or Verzenio (abemaciclib) or Kisqali (ribociclib) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) for their metastatic disease OR Faslodex (fulvestrant) is given in combination with Afinitor (everolimus) for disease that has been treated with endocrine therapy (e.g. letrozole,				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			anastrazole) OR Faslodex (fulvestrant) is given in combination with Piqray (alpelisib) for disease progression on or after endocrine based therapy (e.g. anstrazole, palbociclib) within one year of PIK3CA mutated disease.				
FYCOMPA			Partial-onset seizures: Inadequately controlled partial-onset seizures. Adjunctive treatment for members with generalized tonic-clonic seizures: Inadequately controlled partial-onset seizures and concomitant use of at least one antiepileptic medication.	Adjunctive treatment for generalized tonic-clonic seizures: Age 12 years and older. Partial-onset seizures: age 4 years and older.	Licensed Practitioner	Plan year duration	
GAMIFANT			Primary Hemophagocytic Lymphohistiocytosis (HLH). Initial Authorization: Member has documentation in the medical record of a gene mutation known to cause primary HLH (e.g., PRF1, UNC13D) OR Confirmation that at least 5 of the following clinical characteristics are present: Fever greater than or equal to 101.3 degrees F, Splenomegaly, Two of the following cytopenias in the peripheral		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			blood: Hemoglobin less than 9 g/dL or Platelet count less than 100 x 109/L or Neutrophils less than 1 x 109/L, One of the following: Hypertriglyceridemia defined as fasting triglycerides greater than or equal to 3 mmol/L or greater than or equal to 265 mg/dL or Hypofibrinogenemia defined as fibrinogen less than or equal to 1.5 g/L, Hemophagocytosis in bone marrow or spleen or lymph nodes with no evidence of malignancy, Low or absent natural killer cell activity (according to local laboratory reference), Ferritin greater than or equal to 500 mg/L, Soluble CD25 (i.e., soluble IL-2 receptor) greater than or equal to 2,400 U/ml AND Member has refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (i.e., etoposide + dexamethasone) AND Gamifant (emapalumab-lzsg) will be administered with dexamethasone AND Member is a candidate for stem cell transplant AND Gamifant (emapalumab-lzsg) is being used as part of the induction or maintenance phase of stem cell				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			transplant, which is to be discontinued at the initiation of conditioning for stem cell transplant. Reauthorization Criteria: Member is awaiting stem cell transplant and there is documentation in the medical record demonstrating a positive clinical response from baseline.				
GAMUNEX-C			Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome,X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/µL),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/µL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are		Licensed Practitioner	Plan year duration.	Infections in Low-Birthweight Neonates.Prophylaxis and treatment of infections in high-risk, preterm, low-birth weight members.Diagnosed with staphylococcal / streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, an undrainable focus is present, or has persistent oliguria with pulmonary edema. Diagnosed with autoimmune neutropenia and G-CSF therapy is not appropriate. Autoimmune Hemolytic

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/µL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level				Anemia. Is refractory to corticosteroid therapy and splenectomy. Myasthenia Gravis. Is experiencing acute myasthenic crisis with decompensation.Other treatments have been unsuccessful (e.g., corticosteroids, azathioprine, cyclosporine, and cyclophosphamide). Guillain-Barre Syndrome. Is severely affected by the disease and requires an aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed with hyperimmunoglobulinemia E syndrome. IVIG is needed to treat severe eczema.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			less than 400 mg/dL). AIDS/HIV. Has any of the following conditions:CD4+ T-cell counts greater than or equal 200/mm3 ,To prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).				Diagnosed with multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed with relapsing-remitting multiple sclerosis and has failed conventional therapy (Betaseron, Avonex, etc.).Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs, OR There is muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambart-Eaton

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							myasthenic syndrome confirmed by electrophysiologic studies. Has not responded to diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate is diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections. Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisista,etc. Has tried and failed conventional therapy or has rapidly progressive disease in which a clinical

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							response could not be affected quickly enough using conventional agents.Stiff-Person Syndrome. Other interventions (diazepam) have been unsuccessful. Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or in members with hemolytic anemia/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GATTEX 30-VIAL			Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).		Licensed Practitioner	3 Month Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GATTEX ONE-VIAL			Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).		Licensed Practitioner	3 Month Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GAVRETO		Member experiences disease progression on RET inhibitors (e.g., pralsetinib).	Non-small cell lung cancer: The member has a diagnosis of metastatic non-small lung cancer AND the disease is documented as RET fusion positive AND Gavreto (pralsetinib) is being used as monotherapy.		Licensed Practitioner	6 Months Duration	
GAZYVA		Members that have experienced disease progression while on Gazyva (obinutuzumab). The member will be using obinutuzumab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member is using Gazyva (obinutuzumab) in combination with Chlorambucil OR the member is using Gazyva (obinutuzumab) in combination with bendamustine OR the member is using Gazyva (obinutuzumab) in combination with Venclexta (venetoclax) OR the member is using Gazyva (obinutuzumab) as monotherapy. Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following sets of criteria apply: The member will be using Gazyva (obinutuzumab) for first line therapy OR The member has relapsed after, or is refractory to, a rituximab-containing		Licensed Practitioner	CLL: 6 months. Follicular Lymphoma: Initial auth: 6 months, Reauth: Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).	regimen (defined as progression on or within 6 months of prior rituximab product therapy) AND The member will initially be using Gazyva (obinutuzumab) in combination with chemotherapy (e.g. CHOP, CVP, bendamustine) (after 6-8 cycles Gazyva (obinutuzumab) may be continued as monotherapy per reauthorization criteria below). Follicular Lymphoma--Reauthorization Criteria: The member has achieved stable disease, complete response, or partial response after therapy with Gazyva (obinutuzumab) in combination with chemotherapy (e.g, CHOP, CVP, bendamustine).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GDRIVE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GE100 BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GE100 BLOOD GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GEL-ONE			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
GELSYN-3			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GENSTRIP TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GENULTIMATE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GENVISC 850			Osteoarthritis: The member has documented symptomatic osteoarthritis		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Orthovisc AND Monovisc.				
GILENYA		Combination use with other disease modifying drugs for MS including Avonex, Betaseron, Extavia, Copaxone, Rebif, Tysabri, Aubagio or Tecfidera. Treatment with Class Ia or Class III anti-arrhythmic drugs.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GILOTRIF			Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following apply: The member has a documented non-resistant epidermal growth factor receptor (EGFR) mutation (sensitizing EGFR mutation e.g., exon 19 deletion, L861Q, S768I, G719X, L858R) AND The member is using Gilotrif (afatinib) as monotherapy (without concomitant chemotherapy) OR squamous cell histology after disease progression on platinum containing chemotherapy and is using Gilotrif (afatinib) as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLASSIA		IgA deficient members or presence of antibodies against IgA.	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema).		Licensed Practitioner	Plan Year Duration	
GLATIRAMER			The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLATOPA			The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	
GLEOSTINE		Member has experienced disease progression while on gleostine.	Brain Tumors: Member has a diagnosis of primary or metastastic brain tumor AND one of the following applies: Member will use Gleostine after appropriate surgical and/or radiotherapeutic procedures OR Member has recurrent or progressive disease. Hodgkin Lymphoma: Member has a diagnosis of Hogdkin Lymphoma AND Member has disease progression following initla chemotherapy AND Member will use Gleostine as a component of combination chemotherapy.		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCO NAVII GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCO NAVII TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD 01 METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD 01 SENSOR PLUS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD EXPRESSION			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD SHINE CONNEX METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD SHINE EXPRESS METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD SHINE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD SHINE METER KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD SHINE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD SHINE XL METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD VITAL			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCARD VITAL SENSOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCARD VITAL TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLUCOCOM BLOOD GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GLUCOCOM GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GM100			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GOJJI BLOOD GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GOJJI LANCET-GLUCOSE TEST STRP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GOJJI MULTI-FUNCTIONAL METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GOODLIFE AC-302 GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
GOODLIFE AC-302 TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HAEGARDA		Use for acute treatment of HAE attack. Evidence of autoantibodies against the C1INH protein. Evidence of underlying lymphoproliferative, malignant, or autoimmune disorder that causes angioedema attacks. Use in combination with other agents approved for prophylactic treatment of HAE attack (e.g. Cinryze).	Hereditary Angioedema (HAE) Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Low evidence of C4 level (less than 14 mg/dL) AND Low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (functional C1INH less than 50%) OR Known HAE-causing C1INH mutation. The member must be using Haegarda for prophylaxis and have no signs of current acute angioedema attack.	Pending CMS Approval	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HALAVEN			Breast Cancer. The member has a diagnosis of metastatic breast cancer AND The member has progressive disease following at least two chemotherapeutic regimens for the treatment of metastatic disease AND The member has had prior therapy, contraindication or intolerance with an anthracycline and a taxane in either the adjuvant or metastatic setting.Liposarcoma: The member has a diagnosis of unresectable or metastatic liposarcoma and has received a prior anthracycline containing regimen.		Licensed Practitioner	six months	
HARMONY GLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HARVONI		Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors, polymerase inhibitors, NS5A inhibitors).	Chronic Hepatitis C: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotypes 1a,1b,4,5 and 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C - GT1 treatment naive without cirrhosis and HCV RNA under 6 million will be approved for 8 weeks. Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant, Must must have	The member must be 18 years or older. Pediatric indications: The member must be 3 years or older.	Licensed Practitioner.	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			experienced recurrent HCV infection post-transplant in the allograft liver, Member must be at least 18 years of age, Member must have document genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis, Member must be at least 18 years of age, Member must have genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HEALTHPRO GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
HEALTHPRO TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HELIXATE FS					Licensed Practitioner	Plan Year Duration	
HEMLIBRA		Inherited or acquired bleeding disorder other than hemophilia A. Ongoing immune tolerance induction therapy or prophylaxis with factor VIII replacement agents.	Hemophilia A (Congenital Factor VIII Deficiency). Member has severe hemophilia A (less than 1% of normal factor (less than 0.01 IU/ml)) OR Member has hemophilia A (regardless of normal factor levels) and has documented history of 2 or more episodes of spontaneous bleeding into joints AND Medical records document the member has failed to meet treatment goals with prophylactic factor VIII replacement product therapy (e.g. continuation of spontaneous bleeds) OR Member has medically documented lack of venous access OR Medical records document the presence of factor VIII inhibitors that has rendered replacement factor VIII ineffective (i.e., history of factor VIII inhibitor titer of greater than or equal to 5 Bethesda units per milliliter) AND Physician attestation that the member will not receive extended half-life factor VIII replacement products (e.g., Eloctate,		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes AND Hemlibra (emicizumab-kxwh) will be utilized for prophylaxis to prevent or reduce the frequency of bleeding episodes.				
HEMOFIL M HIGH					Licensed Practitioner	Plan Year Duration	
HEMOFIL M LOW					Licensed Practitioner	Plan Year Duration	
HEMOFIL M MID					Licensed Practitioner	Plan Year Duration	
HEMOFIL M SUPER HIGH					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HERCEPTIN			For Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), or Ontruzant (trastuzumabdttb) requests: member must have an intolerance or contraindication Herceptin (trastuzumab) or Trazimera (trastuzumab–qyyp) or Kanjinti (trastuzumab-anns) and meets below criteria. Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease. Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HERCEPTIN HYLECTA		Member is using concomitantly with Kadcyla (ado-trastuzumab emtansine). Member has a diagnosis of gastric or GEJ or esophageal carcinoma.	Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease AND Member has intolerance or prior treatment with a trastuzumab product [Herceptin (trastuzumab) or biosimilar Herceptin [e.g. Kanjinti (tratuzumab-anns), Trazimera (trastuzumab-qyyp)] and one of the following applies: Member is receiving Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) as adjuvant treatment and In combination with paclitaxel or docetaxel following doxorubicin and cyclophosphamide or In combination with docetaxel and carboplatin or Monotherapy following multimodality anthracycline based therapy OR Member is receiving Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) as treatment for metastatic disease and In combination with paclitaxel as first line treatment or monotherapy following one or more combination chemotherapy treatments.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HETLIOZ			Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz for the treatment of Non-24-Hour Sleep-Wake Disorder AND member has diagnosis of total blindness (i.e no light perception) in both eyes.		Licensed Practitioner	plan year duration	
HUMATE-P					Licensed Practitioner	Plan Year Duration	
HUMIRA		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs.	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.	severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA PEDIATRIC CROHNS START		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or	years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate,

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			contraindication to all conventional oral systemic treatments.				posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA PEN		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or	Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.				Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA PEN CROHNS-UC-HS START		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen).	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe	Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.				must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA PEN PSOR-UVEITS-ADOL HS		Combination therapy with other biologics (e.g.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or	The member must be at least 18 years of age for the following	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Cosentyx, Enbrel, Humira, Kevzara, Remicade)	intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide)	indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.				mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HUMIRA(CF)		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone,

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.				methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA(CF) PEDI CROHNS STARTER		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs.	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.	for Hidradenitis Suppurativa.			intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA(CF) PEN		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.	years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA(CF) PEN CROHNS-UC-HS		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral systemic treatments.	polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA(CF) PEN PSOR-UV-ADOL HS		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade)	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine,	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Ankylosing Spondylitis. The member must be two years of age or older	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone,

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, sulfasalazine) or contraindication to all conventional oral	and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa.			methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			systemic treatments.				member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HYALGAN			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
HYMOVIS			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IBANDRONATE		In patients with severe renal impairment (patients with serum creatinine greater than 200uMol/L [2.3 mg/dL] or creatinine clearance less than 30mL/min.	Postmenopausal Osteoporosis: The member is a postmenopausal with a diagnosis of osteoporosis or at high risk for osteoporosis. The member has new fractures or significant loss of bone mineral density despite previous treatment contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate, ibandronate, pamidronate).		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IBRANCE		Member is on concomitant abemaciclib or ribociclib. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., ribociclib, abemaciclib).	Breast Cancer:The member has a diagnosis of estrogen receptor-positive and human epidermal growth factor receptor 2-negative breast cancer AND one of the following applies: The member will be using Ibrance in combination with an aromatase inhibitor (e.g., letrozole) as initial endocrine-based therapy for their recurrent disease OR The member will be taking Ibrance (palbociclib) in combination with an aromatase inhibitor (e.g., letrozole) as initial endocrine based therapy for their metastatic disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their recurrent disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their metastatic disease.		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ICLUSIG		The member has experienced disease progression while on Iclusig (ponatinib). Members on concomitant tyrosine kinase inhibitors.	Chronic Myeloid Leukemia:The member has a diagnosis of chronic, accelerated, or blast phase chronic myeloid leukemia (CML) AND one of the following apply: The member has not achieved treatment goals, has an intolerance, or resistance to at least two available tyrosine kinase inhibitors indicated for the treatment of CML OR The member has a documented T315I mutation. Acute Lymphoblastic Leukemia: The member has a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) AND one of the following apply: The member has not achieved treatment goals, has an intolerance, or resistance to at least two available tyrosine kinase inhibitors indicated for the treatment of Ph+ ALL OR The member has a documented T315I mutation.		Licensed Practitioner	6 month duration	
IDELVION					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IDHIFA		Member has experienced disease progression while on or following Idhifa(enasidenib)	Acute Myeloid Leukemia – Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH2 mutation AND One of the following applies: The member will be using Idhifa (enasidenib) as monotherapy OR the member will be using Idhifa (enasidenib) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia – Newly diagnosed: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has newly diagnosed disease AND the member is not a candidate for intensive induction therapy due to comorbidities AND the member has a documented IDH2 mutation AND the member will be using Idhifa (enasidenib) as monotherapy.	The member is 60 years of age or older for newly diagnosed AML.	Licensed Practitioner	Six month durations	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IGLUCOSE BLOOD GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
IGLUCOSE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ILARIS (PF)			Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome	4 years or older for Familial Cold	Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(MWS).Systemic Juvenile Idiopathic Arthritis:The member has a diagnosis of systemic juvenile idiopathic arthritis.The member has had prior therapy,contraindication or intolerance with a DMARD (e.g. methotrexate,leflunomide). Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS):The member has a diagnosis of tumor necrosis factor receptor associated periodic syndrome (TRAPS) AND The member must have experienced more than 6 flares/year at baseline. Familial Mediterranean Fever (FMF):The member has a diagnosis of Familial Mediterranean Fever (FMF) AND The member must have at least 1 attack per month at baseline AND The member has had previous treatment, contraindication, or intolerance to colchicine. Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD):The member has a diagnosis of Hyperimmunoglobulin D Syndrome(HIDS)/Mevalonate Kinase	Autoinflammatory Syndrome/Muckle-Wells Syndrome. Age 2 or older for SJIA.			

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Deficiency (MKD) AND The member must have greater than or equal to 3 febrile acute flares in a 6-month period at baseline.				
ILUVIEN		Active ocular or periocular infections. Advanced Glaucoma (e.g. cup to disc ratio of greater than 0.8).	Diabetic Macular Edema:Member has a diagnosis of diabetic macular edema. Member was previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure.		Licensed Practitioner	Plan year duration	
IMATINIB		Patients on concomitant tyrosine kinase inhibitors. Patients that have experienced disease progression while on imatinib.	The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis. Acute lymphoid leukemia (ALL).The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis	The patient is at least one year of age.	Licensed Practitioner	Plan Year Duration	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			of Dermatofibrosacrome protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement. (ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis of unresectable melanoma with activating mutation of C-kit. Imatinib will be used as single agent in subsequent therapy.				therapy.Acute Lymphoid Luekemia (ALL). The member is newly diagnosed with Ph+ ALL AND the member will be using imatinib in combination with chemotherapy.
IMBRUVICA		Members that have experienced disease progression while	Mantle Cell Lymphoma: The member has a diagnosis of Mantle Cell Lymphoma (MCL) AND The member has received at least one prior therapy for the treatment		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on Imbruvica (ibrutinib).	of MCL AND The member is using Imbruvica as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) AND One of the following scenarios apply: The member does not have documented deletion (17p) OR The member has deletion (17p) AND The member will be using Imbruvica (ibrutinib) as monotherapy. Waldenstrom's Macroglobulinemia:The member has a diagnosis of Waldenstrom’s macroglobulinemia AND The member is using Imbruvica (ibrutinib) as monotherapy or in combination with Truxima (rituximab-abbs). Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma AND The member is using Imbruvica (ibrutinib) as second line or subsequent for refractory or progressive disease AND The member is using Imbruvica (ibrutinib) as				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			monotherapy. Chronic Graft Versus Host Disease: The member has a diagnosis of chronic graft versus host disease (cGVHD) AND The member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g. corticosteroids).				
IMFINZI		Disease progression while on anti-PD-1/PD-L1 therapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Imfinzi (durvalumab)]. For NSCLC, member has not exceeded a maximum of twelve (12) months of therapy.	Non-Small Cell Lung Cancer (NSCLC): Member has diagnosis of unresectable stage III non-small cell lung cancer (NSCLC) AND Imfinzi (durvalumab) will be used as consolidation therapy after completion of concurrent platinum containing chemotherapy and radiation AND Member has not experienced progression of disease after at least two cycles of chemotherapy and radiation AND Imfinzi (durvalumab) will be used as monotherapy. Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial cancer AND The member will be using Imfinzi (durvalumab) as a single agent AND One of the following apply: The member will		Licensed Practitioner	6 months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			be using as a second or subsequent line-therapy OR The member has had disease progression within 12 months of neoadjuvant or adjuvant chemotherapy. Small Cell Lung Cancer: The member has a diagnosis of extensive-stage small cell lung cancer AND Imfinzi will be given in combination with etoposide and carboplatin as first line therapy followed by maintenance therapy with Imfinzi as a single agent.				
IMIPRAMINE HCL			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IMIPRAMINE PAMOATE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IMLYGIC		Members who are immunocompromised. Members who are pregnant. Members that have experienced disease progression while on Imlygic (talimogene laherparepvec). Concomitant therapy with anti-PD-1/PD-L1 agents (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]).	Unresectable Melanoma: The member must have one of the following melanoma diagnoses:unresectable Stage III with in-transit metastases, unresectable local/satellite recurrence (may also have in-transit metastases), unresectable or distant metastatic disease. The member will receive Imlygic as an intralesional therapy into cutaneous, subcutaneous, or nodal lesions that are visible on the skin, palpable, or detectable by ultrasound guidance.	The member must be 18 years or older.	Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INCRELEX		The bone epiphyses are closed.	Member has a diagnosis of GH gene deletion with development of neutralizing antibodies to GH OR The patient has a diagnosis of severe primary IGF-1 deficiency defined by:height standard deviation score below -3.0 and basal IGF-1 standard deviation score below -3.0 and normal or elevated growth hormone.	The patient is 2 years or older	Licensed Practitioner	Plan year duration	
INFINITY METER KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INFINITY STARTER KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
INFINITY TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INFINITY VOICE GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
INFINITY VOICE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INLYTA		Members on concomitant tyrosine kinase inhibitors. Members on concomitant mTOR inhibitors.Members that have experienced disease progression while on Inlyta /axitinib.	Renal Cell Carcinoma: The member has a diagnosis of advanced renal cell carcinoma AND Inlyta will be given as one of the following: monotherapy OR in combination with Keytruda or Bavencio as first-line therapy. Advanced Thyroid Carcinoma: The member has a diagnosis of advanced/metastatic follicular carcinoma, Hürthle cell carcinoma, or papillary carcinoma and clinical trials are not available or appropriate AND The member has disease that is not responsive to radio-iodine treatment.		Licensed Practitioner	6 month duration	
INQOVI		The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).	Myelodysplastic Syndromes - Chronic Myelomonocytic Leukemia: The member has a diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo or secondary MDS OR chronic myelomonocytic leukemia (CMML) AND the member will be using Inqovi (decitabine and cedazuridine) as a single agent.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INREBIC		Members that have experienced disease progression while on Inrebic (fedratinib).	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-2 risk disease OR High-risk disease AND the member will be using Inrebic (fedratinib) as monotherapy AND The member has a medical reason as to why Jakafi (ruxolitinib) cannot be used. Reauthorization criteria: Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement) AND physician attestation that the member has not experienced unacceptable toxicities.		Licensed Practitioner	Initial auth: 6 months duration. Reauthorization: 6 months Duration.	
INTRON A			Chronic Hepatitis C. Diagnosis of chronic	Chronic Hep C must 3	Licensed	HepC:24m	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			hepatitis C with compensated liver disease (without jaundice, ascites, active gastrointestinal bleeding, encephalopathy). Documentation of quantitative HCV RNA (viral load). For members 18 years of age older: For treatment naïve members with Hepatitis C, the member must first consider pegylated products (Pegasys or Peg-Intron plus ribavirin) or have a contraindication or other clinical circumstance preventing them from using before the member will be eligible to receive Intron A. For members 3 – 17 years of age: Intron A must be used in combination with ribavirin. Chronic Hepatitis B: Diagnosis of chronic HBeAG-positive hepatitis B with compensated liver. Must have ALT greater than 2x the upper limit of normal and have HBV DNA greater than 20,000 IU/ml. Hairy Cell Leukemia. Diagnosis of hairy cell leukemia. Malignant Melanoma. Diagnosis of malignant melanoma and utilizing Intron A as an adjuvant therapy to surgical treatment. Follicular Non-Hodgkin’s	years or older. Must be 18 years or older for Hairy Cell Leukemia, Malignant Melanoma, Follicular Non-Hodkins Lymphoma, Condylomata Acuminata, AIDS-related Kaposi¿s Sacroma. 1 year or older for Chronic Hep B.	Practitioner	onths, Melanoma,lymphoma:PlanYear,leukemia,HepB:6 months,Condyloma ta:3weeks ,Kaposis:4 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Lymphoma. Diagnosis of follicular non-Hodgkin's lymphoma.Must be utilizing Intron A in conjunction with anthracycline-containing combination chemotherapy. Condylomata Acuminata. Diagnosis of condylomata acuminata involving external surfaces of the genital and perianal areas. AIDS-Related Kaposi's Sarcoma. Diagnosis of AIDS-related Kaposi's sarcoma.				
IRESSA		Members on concomitant tyrosine kinase inhibitors	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the following applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Iressa (gefitinib) as monotherapy (without concomitant chemotherapy).		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ISTODAX		Members that have experienced disease progression while on romidepsin.Members on concomitant hypomethylator (e.g. vorinostat) therapy.	Cutaneous T-cell Lymphoma (CTCL). Istodax (romidepsin) is being used to treat cutaneous T-cell lymphoma AND one of the following applies: the member will be using Istodax (romidepsin) as primary biologic systemic therapy OR the member will be using Istodax (romidepsin) as adjuvant systemic biologic therapy OR the member has received at least one prior therapy. Peripheral T-cell Lymphoma (PTCL).Istodax (romidepsin) is being used to treat relapsed or refractory peripheral T-cell lymphoma. The member has received at least one prior therapy.		Licensed Practitioner.	6 month duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
IXEMPRA		Members that have experienced severve (CTC grade 3/4)hypersensitivity reactions to medications formulated with Cremophor EL/ polyoxyethylated castor oil. Ixempra (ixabepilone) should be discontinued after disease progression constituting treatment failure.	Breast Cancer.The member has a diagnosis of locally advanced or metastatic breast cancer and one of the following: When used as monotherapy: the member has disease that is refractory or resistant to an anthracycline (e.g. Doxorubicin),a taxane(e.g.paclitaxel) and Xeloda (capecitabine)OR When used in conjunction with Xeloda (capecitabine) (or 5-FU/fluorouracil): the member has disease that is refractory to both an anthracycline (e.g. Doxorubicin),and a taxane (e.g.paclitaxel)(or further anthracycline therapy is contraindicated and disease is refractory to a taxane).		Licensed Practitioner	six months	
IXINITY					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
JADENU		On concomitant Desferal or Ferriprox.Member has platelet count less than 50x109/L	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload:The member has a diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. For initial approval: Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment)For reauthorizations: Ferritin level must be consistently above 500mcg/L-deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndromes:The member has a diagnosis of non-transfusion dependent thalassemia syndrome AND The member has a liver iron concentration (LIC) of at least 5mg / g of liver dry weight (mg FE/g dw) AND The member has a serum ferritin greater than 300mcg/L		Licensed Practitioner	Plan year duration	
JAKAFI		Jakafi (ruxolitinib) therapy is not considered	Myelofibrosis.The member has a documented diagnosis of primary myelofibrosis, post-polycythemia vera	The member is 12 years of age or older for acute graft versus	Licensed Practitioner	Initial Authorization: 6	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Jakafi (ruxolitinib).Members on concomitant tyrosine kinase inhibitors or immunomodulatory medications (example: Revlimid/lenalidomide)	myelofibrosis or post-essential thrombocythemia myelofibrosis AND The member has one of the following risk categories, as defined by International Prognostic Scoring System (IPSS): Symptomatic low risk disease OR Symptomatic intermediate-1 risk disease OR Intermediate-2 risk disease OR High risk disease. The member will be using Jakafi (ruxolitinib) as monotherapy (excludes medically necessary supportive agents). Polycythemia Vera: The member has a diagnosis of polycythemia vera AND The member has not achieved treatment goals, has an intolerance, or contraindication to hydroxyurea. Acute Graft Versus Host Disease: The member has a diagnosis of steroid-refractory acute graft versus host disease. Reauthorization criteria. Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement, hematocrit control) AND Physician attestation that the member has	host disease.		months. Reauthorization: 6 months.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			not experienced unacceptable toxicities.				
JAZZ WIRELESS 2 METER KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
JELMYTO		Member has perforation of the bladder or upper urinary tract.	Low-Grade Upper Tract Urothelial Cancer (LG-UTUC): Member has a diagnosis of noninvasive low-grade Upper Tract Urothelial Cancer (LG-UTUC) AND Disease is not metastatic.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
JETREA (PF)		Members with proliferative diabetic retinopathy, neovascular age-related macular degeneration, uncontrolled glaucoma or a macular hole greater than 400 µm in diameter. Members that have previously had a vitrectomy procedure in the affected eye(s). Members that have received prior treatment with Jetrea (ocriplasmin) in the affected eye(s).	Vitreomacular Adhesion.The member has documented, symptomatic vitreomacular adhesion diagnosed via scanning computerized ophthalmic diagnostic imaging (ie optical coherence tomography).		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
JEVTANA		Jevtana should not be administered to patients with neutrophils less than or equal to 1,500/mm3. Jevtana should not be given to patients with hepatic impairment (total bilirubin greater than 3 x ULN. Concomitant use with abiraterone acetatate, Yonsa, or Xtandi.	Hormone-Refractory Metastatic Prostate Cancer. The member must have a diagnosis of hormone-refractory metastatic prostate cancer. The member must have previously been treated with a docetaxol-containing treatment regimen. The member must be taking Jevtana in combination with prednisone.		Licensed Practitioner	Plan Year Duration	
JIVI					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KADCYLA		The member has experienced disease progression while on Kadcyla (ado-trastuzumab emtansine. Use in the adjuvant setting. Members on concomitant trastuzumab product, Tykerb (lapatinib), or Perjeta (pertuzumab).	Metastatic Breast Cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease AND the member is using Kadcyla (ado-trastuzumab emtansine) as monotherapy AND the member has received prior therapy with a trastuzumab product and a taxane (eg. paclitaxel, docetaxel), separately or in combination and one of the following applies: Received prior treatment for metastatic disease. Recurrence occurred during or within six months of completing adjuvant therapy. Early Breast cancer: The member has a diagnosis of early HER 2 positive breast AND the member has received neoadjuvant taxane (e.g. paclitaxel) and trastuzumab containing regimen AND the member is receiving Kadcyla (ado-trastuzumab emtansine) as adjuvant treatment.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KALYDECO			Cystic Fibrosis: The member has a diagnosis of Cystic Fibrosis. The member has a documentation of one of the following mutations in the CFTR gene: A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G, E193K, E56K, F1052V, F1074L, G1069R, G551D, G1244E, G1349D, G178R, G551S, K1060T, L206W, P67L, R117C, R117H, R347H, R352Q, R74W, R1070W, R1070Q, S1251N, S1255P, S549N, S945L, S977F, S549R, 711+3A-G, E831X, 2789+5G-A, 3272-26A-G, or 3849+10kbC-T.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KANJINTI			For Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), or Ontruzant (trastuzumabdttb) requests: member must have an intolerance or contraindication Herceptin (trastuzumab) or Trazimera (trastuzumab–qyyp) or Kanjinti (trastuzumab-anns) and meets below criteria. Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease. Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KEVZARA		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade).	Moderate to Severe Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis AND the member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide) or contraindication to all DMARDs.	The member must be at least 18 years of age or older.	Licensed Practitioner.	Plan year duration.	
KEYTRUDA		Disease progression while on or following prior anti-PD-1/PD-L1 therapy (e.g., nivolumab, atezolizumab). Member requiring urgent cytoreductive therapy (applicable to PMBCL only).	Melanoma: unresectable or metastatic melanoma OR melanoma AND will be used as monotherapy for adjuvant treatment after complete resection with involvement of lymph node(s). NSCLC-1st Line: metastatic NSCLC AND 1 of the following applies: disease with PD-L1 expression [TPS greater than or equal to 1%] with no EGFR or ALK genomic tumor aberrations and as 1st line AND tumor expresses PD-L1 as determined by an FDA-approved test AND used as monotherapy OR nonsquamous histology and in combo with pemetrexed and carboplatin or cisplatin as 1st line therapy followed by Keytruda maintenance in		Licensed Practitioner	6 months duration	MSI-High/d-MMR Solid tumors: unresectable or metastatic documented microsatellite instability-high or mismatch repair deficient solid tumors (excluding pediatric patients with MSI-H central nervous system cancers) AND 1 of the following applies: disease that progressed on prior therapy with no alternative treatments and given as monotherapy OR diagnosis of colorectal cancer AND 1 of the following: Keytruda as

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			combo with pemetrexed OR squamous histology and used in combo with carboplatin and paclitaxel or Abraxane as 1st line followed by Keytruda maintenance OR stage III NSCLC and not candidate for surgical resection or definitive chemoradiation AND PD-L1 expression with no EGFR or ALK genomic tumor aberrations and as 1st line AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. NSCLC-Subsequent: metastatic NSCLC AND progression on or following chemo and EGFR inhibitor, if EGFR mutation positive or ALK inhibitor, if ALK positive AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. Head-Neck Cancer: recurrent or metastatic non-nasopharyngeal head and neck squamous cell carcinoma AND 1 of following: disease progression on platinum-containing chemo and as monotherapy OR in combo with platinum and 5-FU for 1st line treatment OR monotherapy in 1st line and				monotherapy and as subsequent therapy after progression on treatment with fluoropyrimidine, oxaliplatin, and irinotecan or 1st line as monotherapy in unresectable or metastatic colorectal cancer with previous treatment with adjuvant FOLFOX or CapeOX within the past 12 months. Urothelial Cancer: locally advanced or metastatic urothelial cancer AND as monotherapy AND 1 of the following: initial therapy in members ineligible for cisplatin containing chemotherapy and disease expressing CPS score greater than or equal to 10 OR initial therapy in members ineligible to receive platinum containing chemo regardless of PD-L1 status OR as

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			disease expresses CPS score greater than or equal to 1 as detected by an FDA-approved test. Hodgkin's Lymphoma-Adult: used as monotherapy as 3rd line or subsequent treatment AND relapsed or refractory disease and 1 of the following: after autologous hematopoietic stem cell transplant or transplant-ineligible OR post-allogenic transplant. Hodgkin's Lymphoma-Pediatric: as monotherapy and 1 of following: Refractory disease OR Relapsed after 3 or more lines of prior therapy.				subsequent therapy after disease progression within 12 months of neoadjuvant or adjuvant chemo. Gastric Cancer: recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma AND experienced disease progression on or after 2 or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemo and if appropriate, HER2/neu-targeted therapy AND disease expresses PD-L1 as determined by an FDA-approved test AND as subsequent therapy as a single agent. Cervical Cancer: recurrent or metastatic cervical cancer AND progression on or after chemo AND disease expresses CPS score greater

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							than or equal to 1 as determined by an FDA approved test AND as monotherapy. Primary Mediastinal Large B-Cell Lymphoma-Adults and pediatrics: Relapsed or refractory disease after 2 or more prior lines of treatment AND as monotherapy. Merkel cell carcinoma-Adult and pediatric: recurrent locally advanced or metastatic merkel cell carcinoma AND as monotherapy. HCC: has prior therapy with Nexavar AND as monotherapy. RCC: advanced or metastatic RCC AND given in combo with Inlyta as 1st line therapy. SCLC–metastatic: as subsequent line of therapy after progression on platinum based therapy and 1 other therapy. Esophageal Cancer:

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							recurrent locally advanced or metastatic squamous cell carcinoma of the esophagus AND disease expresses PD-L1 as determined by an FDA approved test AND will be given subsequent therapy as a single agent. Endometrial cancer: metastatic or recurrent endometrial cancer AND not MSI-H or dMMR AND not candidate for surgery or radiation AND has disease progression on prior systemic therapy AND given in combo with Lenvima as subsequent therapy. NMIBC with carcinoma in situ AND ineligible for or has elected not to undergo cystectomy AND has BCG-unresponsive disease, defined as persistent or recurrent high-grade bladder cancer within 6 months of intravesical BCG

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							therapy AND as monotherapy.
KISQALI		Member is on concomitant palbociclib or abemaciclib. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib)	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) or Verzenio (abemaciclib) cannot be started or continued as initial endocrine based therapy OR The member will be using Kisqali (ribociclib) in combination with aromatase inhibitor (e.g.,letrozole) as initial endocrine-based therapy for their metastatic disease AND The member is pre/peri menopausal and taking LHRH agonist (eg, leuprolide) concomitantly or treated with ovarian ablation. Breast		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Cancer- Combination with Faslodex (fulvestrant). The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer and one of the following applies: The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as initial endocrine based therapy AND The member is post-menopausal OR The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) AND The member has a medical reason as to why Ibrance (palbociclib) or Verzenio (abemaciclib) cannot be started or continued as subsequent therapy.				
KISQALI FEMARA CO-PACK		Member is on concomitant palbociclib or abemaciclib. Member has	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib)	2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) or Verzenio (abemaciclib) cannot be started or continued as initial endocrine based therapy OR The member will be using Kisqali (ribociclib) in combination with aromatase inhibitor (e.g.,letrozole) as initial endocrine-based therapy for their metastatic disease AND The member is pre/peri menopausal and taking LHRH agonist (eg, leuprolide) concomitantly or treated with ovarian ablation. Breast Cancer- Combination with Faslodex (fulvestrant). The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer and one of the following applies: The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as initial				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			endocrine based therapy AND The member is post-menopausal OR The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as subsequent therapy after disease progression on or following endocrine based therapy (e.g., anastrazole) AND The member has a medical reason as to why Ibrance (palbociclib) or Verzenio (abemaciclib) cannot be started or continued as subsequent therapy.				
KOATE					Licensed Practitioner	Plan Year Duration	
KOGENATE FS					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KORLYM		Pregnancy. Members with a history of unexplained vaginal bleeding. Members with endometrial hyperplasia with atypia or endometrial carcinoma. Concurrent long-term corticosteroid use.	Hyperglycemia secondary to hypercortisolism. Diagnosis of endogenous Cushing's syndrome. AND Type 2 diabetes mellitus or glucose intolerance. AND Failed surgery or are not candidates for surgery.		Licensed Practitioner	Plan Year Duration	
KOSELUGO		Member experienced disease progression on Koselugo (selumetinib).	Neurofibromatosis type 1: The member has a diagnosis of neurofibromatosis type 1 which is symptomatic, inoperable plexiform neurofibromas and Koselugo (selumetinib) is given as a monotherapy.	The member is 2 years of age or older.	Licensed Practitioner	Plan Year Duration	
KOVALTRY					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KRYSTEXXA		Asymptomatic hyperuricemia, Glucose-6-phosphate dehydrogenase (G6PD) deficiency.	Refractory Chronic Gout. The member must have a diagnosis of chronic gout refractory to conventional therapy (treatment failure gout). A baseline serum uric acid level of greater than 6 mg/dL must be established prior to initial Krystexxa (pegloticase) administration. The member has previous treatment, contraindication, or intolerance with allopurinol and a probenecid containing medication (e.g probenecid or probenecid-colchicine).	The member must be 18 years or older.	Licensed Practitioner	Plan Year Duration	
KUVAN			BH4 (Sapropterin) responsive PKU. Diagnosis of PKU that is responsive to BH4. Response is defined as a 20% or greater reduction of blood Phe level from baseline during treatment for one to two months.		Licensed Practitioner	First approval: three months. if response is positive extended for plan year duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
KYMRIAH		Any prior gene therapy product. Any prior anti-CD19/anti-CD3 therapy, or any other anti-CD19 therapy.	Acute Lymphoblastic Leukemia. The member has a diagnosis of B- cell precursor acute lymphoblastic leukemia (ALL)AND The member has refractory disease or is in second or subsequent relapse AND The member has documented CD19 expression in bone marrow or peripheral blood AND The member will be using Kymriah in conjunction with lymphodepleting chemotherapy (fludarabine 30 mg/m2 daily for 4 days and cyclophosphamide 500mg/m2 daily for 2 days) AND The member will be using Kyrmriah (tisagenlecleucel) at a treatment center that is certified to administer Kymriah (tisagenlecleucel)	The member is up to 25 years of age	Licensed Practitioner	60 days duration or as determined through clinical review. Maximum of one dose per lifetime.	
KYPROLIS		Members receiving concomitant therapy with a proteasome inhibitor.The member has experienced	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member is using Kyprolis (carfilzomib) as a single agent or in combination with dexamethasone for disease relapse or progressive disease OR the member will be using Kyprolis (carfilzomi) in		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		disease progression while on Kyprolis(carfilzomib).	combination with Farydak (panobinostat) and the member has received at least two prior regimens, including both bortezomib and an immunomodulatory drug (e.g. thalidomide, lenalidomide, pomalidomide) OR the member will be using Kyprolis (carfilzomib) in combination with Pomalyst (pomalidomide) and dexamethasone and the member has received at least two prior therapies, including an immunomodulatory agent (e.g. thalidomide, lenalidomide, pomalidomide) and a proteasome inhibitor (e.g. bortezomib) AND the member has demonstrated disease progression on or within 60 days of completion of the last therapy OR The member will be using Kyprolis (carfilzomib) in combination with Revlimid (lenalidomide) and dexamethasone or in combination with cyclophosphamide and dexamethasone and one of the following applies: Is using as primary therapy OR Using for treatment of disease relapse (for transplant candidates, disease relapse				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			must be after 6 months following primary chemotherapy with the same regimen) or progressive disease OR the member will be using Kyprolis (carfilzomib) in combination with Darzalex (daratumumab) and dexamethasone and the member has received at least one prior line of therapy. Waldenstrom's Macroglobulinemia: The member has a diagnosis of Waldenstrom's macroglobulinemia AND Kyprolis (carfilzomib) will be used as a component of CaRD regimen (carfilzomib, rituximab, and dexamethasone) as primary therapy OR for relapsed disease (if CaRD previously used as primary therapy relapse must occur after 24 months).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LARTRUVO		Member has disease progression on Lartruvo (olaratumab).	Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma (which includes angiosarcoma, retroperitoneal or intraabdominal or extremity/superficial trunk, head/neck soft tissue sarcoma, and rhabdomyosarcoma) that is not curable by radiation or surgery AND the member has had no prior exposure to anthracycline (e.g., doxorubicin) AND Lartruvo (olaratumab) will be given in combination with doxorubicin (excluding liposomal doxorubicin). Soft Tissue Sarcoma - Reauthorization Criteria. The member has evidence of response AND the member has not experienced grade 3 or 4 infusion related reaction with previous Lartruvo (olaratumab) and doxorubicin therapy AND combination therapy of doxorubicin and Lartruvo (olaratumab) will be given for a total of eight cycles.		Licensed Practitioner	4 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LATUDA		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Diagnosis of Schizophrenia or Schizoaffective Disorder: The member must have prior therapy, intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Diagnosis of Bipolar I Disorder (Bipolar Depression): The member must have documentation of prior therapy, intolerance, or contraindication to quetiapine.	For diagnosis of Schizophrenia or schizoaffective disorder, the member must be 13 years of age or older. For diagnosis of Bipolar I Disorder (Bipolar Depression), the member must be 10 years of age or older.	Licensed Practitioner.	Plan Year Duration.	
LEDIPASVIR-SOFOSBUVIR		Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors, polymerase inhibitors, NS5A inhibitors).	Chronic Hepatitis C: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotypes 1a,1b,4,5 and 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C - GT1 treatment naive without cirrhosis and HCV RNA under 6 million will be approved for 8 weeks. Pediatrics:	The member must be 18 years or older. Pediatric indications: The member must be 3 years or older.	Licensed Practitioner.	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant, Must must have experienced recurrent HCV infection post-transplant in the allograft liver, Member must be at least 18 years of age, Member must have document genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis, Member must be at least 18 years of age,				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member must have genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.				
LENVIMA		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Lenvima (lenvatinib).	Thyroid Cancer:The member has a diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (i.e. papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma) AND The tumors are not responsive to radio-iodine treatment AND Lenvima (lenvatinib) will be used as monotherapy. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma AND the member is using in combination with Afinitor (everolimus) AND the member has experienced intolerance on Inlyta (axitinib) or Cabometyx (cabozantinib) as second line therapy [e.g., severe		Licensed Practitioner	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Hepatocelluar Carcinoma: The member has a diagnosis of unresectable carcinoma AND Lenvima (lenvatinib) will be given as a single agent as first line therapy. Endometrial cancer: The member has a diagnosis of metastatic or recurrent endometrial cancer AND The disease is not MSI-H or dMMR AND The member is not a candidate for surgery or radiation AND The member has experienced disease progression on prior systemic therapy AND Lenvima (levantinib) will be given in combination with Keytruda (pembrolizumab) as subsequent therapy.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LETAIRIS		The patient is concomitantly taking endothelin receptor antagonist (e.g., Tracleer, Opsumit). Member has a diagnosis of idiopathic pulmonary fibrosis.	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. For Brand Request: Member must have had previous treatment, intolerance, or contraindication with a generic ERA (e.g., ambrisentan, bosentan).		Licensed Practitioner	Plan Year Duration	
LEVOLEUCOVORIN CALCIUM		Fusilev (levoleucovorin) is considered not medically necessary for members with the following concomitant conditions:Members with pernicious anemia or megaloblastic anemia secondary to the lack of	Fusilev/levoleucovorin will require prior authorization and may be considered medically necessary when the following criteria are met: Levoleucovorin rescue is indicated after high-dose methotrexate therapy in osteosarcoma. The patient is being treated with methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Levoleucovorin is also indicated		Licensed Practitioner	six months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		vitamin B12	to diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent overdosage of folic acid antagonists.The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy.The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.Advanced Metastatic Colorectal Cancer.The member has advanced metastatic colorectal cancer.The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil.The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LIBTAYO		Member has experienced disease progression on or after prior PD-1/PD-L1 inhibitor (e.g., Keytruda).	Cutaneous squamous cell carcinoma. The member has a diagnosis of locally advanced or metastatic cutaneous squamous cell carcinoma (CSCC) AND The disease is not amenable to curative surgery or radiation AND Libtayo (cemiplimab-rwlc) is being used as a monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LIDOCAINE			Post-Herpetic Neuralgia. The member must have a diagnosis of post-herpetic neuralgia.Diabetic Neuropathy.The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member must have a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. The member will be using lidocaine patch as adjuvant therapy with either acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID). The member has had previous treatment with lidocaine 2% jelly. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. The member will be using lidocaine patch as adjuvant therapy with either acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID). The member has had previous treatment with lidocaine 2% jelly.		Licensed Practitioner	Plan Year Duration	
LIPODOX			Ovarian Cancer: The member has a		Licensed	6 months	Non-Hodgkin's lymphoma:

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of persistent or recurrent ovarian cancer and one of the following applies: if platinum sensitive, in combination with carboplatin OR if platinum resistant, as a single agent or in combination with bevacizumab product, in patients who have not previously received bevacizumab product OR The member has a diagnosis ovarian cancer and Liposomal doxorubicin will be used in combination with carboplatin and one of the following applies: neoadjuvant treatment in members who are poor surgical candidates or low likelihood of optimal cytoreduction or adjuvant treatment or primary treatment in members with incomplete previous surgery or staging. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression after treatment with or intolerance to anthracycline based therapy. Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's		Practitioner	duration	The member has a diagnosis of T-Cell Leukemia or Lymphoma AND Liposomal doxorubicin is given in combination with gemcitabine and vinorelbine as second line or subsequent therapy and one of the following applies: non-responders for acute subtypes or prior to proceeding to transplant OR The member has diagnosis of diffuse large B cell lymphoma AND Liposomal doxorubicin is given in combination with RCDOP (rituximab product, cyclophosphamide, vincristine and prednisone) in members with documented poor ventricular OR The member has a diagnosis of Mycosis Fungoides (MF)/Sezary Syndrome (SS) and liposomal doxorubicin is

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to anthracycline based therapy. Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy or the member is using Liposomal doxorubicn as first line therapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade.				given and one of the following: primary treatment OR as combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant OR The member has a diagnosis of relapsed or refractory peripheral T-cell lymphoma (not otherwise specified or enteropathy associated Tcell lymphoma) AND Liposomal doxorubicin is given as subsequent therapy in combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant.
LIPODOX 50			Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer and one of the following applies: if platinum sensitive, in combination with carboplatin OR if platinum resistant, as a single agent or in		Licensed Practitioner	6 months duration	Non-Hodgkin's lymphoma: The member has a diagnosis of T-Cell Leukemia or Lymphoma AND Liposomal doxorubicin is given in combination with

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			combination with bevacizumab product, in patients who have not previously received bevacizumab product OR The member has a diagnosis ovarian cancer and Liposomal doxorubicin will be used in combination with carboplatin and one of the following applies: neoadjuvant treatment in members who are poor surgical candidates or low likelihood of optimal cytoreduction or adjuvant treatment or primary treatment in members with incomplete previous surgery or staging. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression after treatment with or intolerance to anthracycline based therapy. Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to anthracycline based				gemcitabine and vinorelbine as second line or subsequent therapy and one of the following applies: non-responders for acute subtypes or prior to proceeding to transplant OR The member has diagnosis of diffuse large B cell lymphoma AND Liposomal doxorubicin is given in combination with RCDOP (rituximab product, cyclophosphamide, vincristine and prednisone) in members with documented poor ventricular OR The member has a diagnosis of Mycosis Fungoides (MF)/Sezary Syndrome (SS) and liposomal doxorubicin is given and one of the following: primary treatment OR as combination therapy with gemcitabine and vinorelbine prior to

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapy. Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy or the member is using Liposomal doxorubicn as first line therapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade.				proceeding to transplant OR The member has a diagnosis of relapsed or refractory peripheral T-cell lymphoma (not otherwise specified or enteropathy associated Tcell lymphoma) AND Liposomal doxorubicin is given as subsequent therapy in combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant.
LONSURF		The member has experienced disease progression while on Lonsurf.	Metastatic Colorectal Cancer:The member has a diagnosis of metastatic colorectal cancer AND The member is using Lonsurf as monotherapy AND The member has experienced disease progression, intolerance, or contraindication with ALL of the following therapies: fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine),oxaliplatin-based chemotherapy, irinotecan-based		Licensed Practitioner	Six months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			chemotherapy, and anti-VEGF therapy (e.g. bevacizumab, ziv-aflibercept) AND If the member is RAS wild-type: the member has experienced disease progression,intolerance, or contraindication with anti-EGFR therapy (e.g. cetuximab or panitumumab). Gastric cancer. The member has recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma AND The member has experienced disease progression on or after two lines of therapy including fluoropyrimidine, platinum (e.g., cisplatin), either taxane (e.g., paclitaxel) or irinotecan and if appropriate, HER2/neu-targeted therapy (e.g., trastuzumab) AND Lonsurf will be given subsequent therapy as a single agent.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LORBRENA		Members on concomitant ALK inhibitors (e.g., Zykadia [certinib], Alecensa [alectinib]). Members experience disease progression on Lorbrena (lorlatinib).	Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Lorbrena (lorlatinib) will be given as monotherapy AND one of the following applies in the metastatic setting: Subsequent therapy after disease progression on Xalkori (crizotinib) and one other ALK inhibitor (e.g., alectinib, ceritinib) OR Subsequent therapy after disease progression on Alecensa (alectinib) or Zykadia (ceritinib) as first line therapy. Non- small cell lung cancer [ROS-1 rearrangement]: The member has a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer AND The disease is positive for documented ROS-1 rearrangement and following disease progression on Xalkori (crizotinib), Rozlytrek (entrectinib), or Zykadia (ceritinib) AND Lorbrena (lorlatinib) will be given as a single agent as subsequent therapy.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUCENTIS		Current infection, ocular or periocular. Lucentis should not be used concurrently with other VEGF inhibitors for intraocular use in the absence of documentation indicating that individual products are to be used in different eyes.	Neovascular (WET) Age-Related Exudative Macular Degeneration (AMD). Member is diagnosed with neovascular (wet) age-related macular degeneration AND member has had prior therapy, contraindication or intolerance to bevacizumab. Macular Edema following Retinal Vein Occlusion (RVO). Member is diagnosed with macular edema following retinal vein occlusion AND member has had prior therapy, contraindication, or intolerance to bevacizumab. Diabetic Macular Edema (DME). Member is diagnosed with Diabetic Macular Edema AND member has had prior therapy, contraindication, or intolerance to bevacizumab. Diabetic Retinopathy. Member is diagnosed with diabetic retinopathy AND member has had prior therapy, contraindication, or intolerance to bevacizumab. Myopic Choroidal Neovascularization (mCNV): Member is diagnosed with Myopic Choroidal Neovascularization (mCNV) AND member has had prior therapy contraindication, or		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			intolerance to bevacizumab.				
LUMIZYME			Alglucosidase alpha (Lumizyme) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Members must have a diagnosis of Pompe disease.		Licensed Practitioner.	Plan Year	
LUMOXITI		The member has experienced disease progression while on or following Lumoxiti (moxetumomab pasudotox-tdfk).	Hairy cell leukemia. The member has a diagnosis of relapsed or refractory hairy cell leukemia AND The member has received at least two prior therapies, including treatment with a purine nucleoside analog (e.g. cladribine, pentostatin) AND The member will be using Lumoxiti (moxetumomab pasudotox-tdfk) as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT (3 MONTH)		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT (4 MONTH)		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT (6 MONTH)		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT-PED		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT-PED (3 MONTH)		Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).		Licensed Practitioner	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUTATHERA			Neuroendocrine Tumors (NETs): Member has a diagnosis of unresectable, locally advanced or metastatic gastroenteropancreatic, lung, thymus, or phenochromocytoma/paraganglioma neuroendocrine tumor (NET) AND member has somatostatin receptor based imaging documenting somatostatin receptor-positive NET AND Member has received long acting somatostatin analog (SSA) therapy (i.e., Somatuline Depot OR Sandostatin LAR) for a duration of at least 12 weeks AND Member has not received a prior course of therapy with Lutathera (i.e., maximum of 4 doses at intervals of at least 8 weeks).		Licensed Practitioner	Plan year duration	
LUXTURNA		Member must not have had previous sub-retinal administration of a gene therapy vector, or voretigene neparvovec-rzyl	RPE65 mutation-associated retinal dystrophy: The member has clinical documentation confirming diagnosis of RPE65 mutation-associated retinal dystrophy (e.g. Leber congenital amaurosis Type 2 (LCA 2) or retinitis pigmentosa type 20) including clinical features, funduscopic appearance, and	The member must be between 12 months to 65 years of age.	Licensed Practitioner	Six months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		into the operative eye. Pre-existing eye conditions, intraocular surgery or complications that preclude the ability to administer and assess the efficacy of voretigene neparvovec-rzyl including but not limited to: Malignancies whose treatment could affect central nervous system function, retinopathy associated with diabetic macular edema or sickle cell disease, or Immunodeficiency (acquired or	results of testing such as dark-adapted thresholds, Ganzfeld-flash ERG, and perimetry when appropriate AND The member must have a documented positive genetic test result confirming biallelic RPE65 mutation (homozygote or compound heterozygote). When results demonstrate two different mutations on the RPE65 gene, segregation analysis should be performed when possible* to confirm biallelic involvement (trans-configuration). Patients with two mutations involving only one copy of the RPE65 gene (cis-configuration) are excluded from coverage AND (*Note: If the patient is adopted, or both parents are deceased, segregation analysis may not be possible. In these situations, the two identified RPE65 variants can be assumed to be in trans-configuration if an inherited retinal disease specialist confirms that the phenotype in the patient matches the gene's disease association with a high degree of specificity.) The member must have				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		congenital) making the member susceptible to opportunistic infection.	sufficient viable retinal cells as determined by the treating physician(s) using one of the following criteria: An area of retina within the posterior pole of greater than 100 um thickness shown on OCT or Greater than or equal to 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole or Remaining visual field within 30 degrees of fixation as measured by a lll4e isopter or equivalent (both eyes).				
LYNPARZA		Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g. Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].	Breast Cancer: Member has a diagnosis of recurrent or metastatic breast cancer AND Member has deleterious germline or suspected germline BRCA-mutated disease as detected by an FDA-approved test AND Member has HER-2 negative disease, hormone receptor positive or negative, treated with prior chemotherapy and/or endocrine therapy AND Lynparza will be used as subsequent therapy as a single agent. Ovarian Cancer First Line Maintenance Therapy: The member has a diagnosis of advanced		Licensed Practitioner	6 month duration	Pancreatic Adenocarcinoma - First line maintenance therapy: Member has a diagnosis of metastatic pancreatic adenocarcinoma AND member has deleterious germline or suspected germline BRCA-mutated disease AND member's disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND member's disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation or genomic instability. Member is in complete response or partial response to first line treatment with platinum based chemotherapy. Ovarian Cancer Second Line Maintenance Therapy: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Lynparza (olaparib) tablets as monotherapy (capsules not indicated for maintenance therapy). *Discontinue Avasatin before initiating maintenance therapy with Lynparza. Ovarian Cancer Fourth Line Treatment: The member has a				Metastatic Castration-Resistant Prostate Cancer (mCRPC): Member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND Member has documented deleterious or suspected deleterious germline, or somatic homologous recombination repair (HRR) gene-mutated disease AND Member has experienced progressive disease following prior treatment with Xtandi (enzalutamide) or abiraterone AND Member will use Lynparza (olaparib) in combination with androgen deprivationtherapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of advanced ovarian cancer AND The member has deleterious or suspected deleterious germline BRCA mutation (as detected by an FDA-approved test) AND The member has been treated with three or more prior lines of chemotherapy AND The member will be using Lynparza (olaparib) as monotherapy (capsules or tablets).				
MACRILEN		BMI of greater than 40 kg/m2. History of seizure.	Growth Hormone Deficiency Diagnostic Agent in Adults. The member has a suspected growth hormone deficiency (e.g. structural hypothalamic or pituitary disease, surgery or irradiation to hypothalamus or pituitary, head trauma as an adult, evidence of other pituitary hormone deficiency, or idiopathic childhood-onset growth hormone deficiency) AND The member has a contraindication (e.g. known or at high risk for coronary artery disease) or intolerance to the insulin tolerance test (ITT).	The member must be 18 years of age or older.	Licensed Practitioner	30 days	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MACUGEN		Current infection, ocular or periocular. Macugen should not be used concurrently with other VEGF inhibitors for intraocular use in the absence of documentation indicating that individual products are to be used in different eyes.	Age Related Exudative Macular Degeneration. Member is diagnosed with neovascular (wet) age-related macular degeneration AND the member has had prior therapy, contraindication, or intolerance to bevacizumab.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MARQIBO		Members who have experienced disease progression on Marqibo (vincristine sulfate liposome injection).	Acute Lymphoblastic Leukemia: The member has a diagnosis of relapsed/refractory Philadelphia chromosome-negative (Ph-) acute lymphoblastic leukemia (ALL) or member has a diagnosis of Philadelphia chromosome (Ph+) disease that is refractory to tyrosine kinase inhibitor therapy AND Marqibo will be used as a single-agent salvage therapy AND The member has had disease progression following vincristine sulfate AND One of the following applies: The member is beyond second relapse. The member has had disease progression following two or more therapies.		Licensed Practitioner	6 month duration	
MEKINIST		Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab),	Melanoma-Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist as a single-agent (member has not received prior BRAF-inhibitor therapy)		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Keytruda (pembrolizumab), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf	OR in combination with Tafinlar (dabrafenib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer(NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Mekinist (trametinib) in combination with Tafinlar (dabrafenib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist (trametinib) in combination with Tafinlar (dabrafenib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafinlar (dabrafenib) in				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib).] Adjuvant melanoma only: member is taking Mekinist (trametinib) total treatment for more than one year.	combination with Mekinist (trametinib).				
MEKTOVI		Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic(cobimetini	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Colorectal Cancer - [Braftovi (encorafenib) requests only]: The member has documented BRAFV600E metastatic metastatic colorectal cancer		Licensed Practitioner	Six month durations or as determined through clinical review	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		b), Tafinlar (dabrafenib), or Mekinist (trametinib) OR Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].	and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab).				

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MEMANTINE		Diagnosis of Autism or Atypical Autism (PDD)		An automatic approval if member is greater than 26 years of age.Prior Auth required for age 26 or younger.	Licensed Practitioner	Plan year duration.	
MICRO BLOOD GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MICRODOT BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
MICRODOT XTRA BLOOD GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MODAFINIL			Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated with Narcolepsy,obstructive sleep apnea,or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). Steinert myotonic dystrophy syndrome.Member must have hypersomnia due to Steinert myotonic dystrophy syndrome.		Licensed Practitioner	Plan Year Duration	
MOLINDONE		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older. Drug or alcohol induced severe central nervous system depression.	Schizophrenia: The member must utilize molindone hydrochloride for the management of clinically diagnosed schizophrenia. The member must have documentation of prior therapy, intolerance, or contraindication to two (2) of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MONJUVI		The member has experienced disease progression on anti-CD-19-directed therapy.	Diffuse large B-cell lymphoma: The member has a diagnosis of diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma (e.g. follicular lymphoma) AND The member has relapsed or refractory disease AND The member is not eligible for autologous stem cell transplant AND The member will be using Monjuvi (tafasitamab-cxix) in combination with lenalidomide for a maximum of 12 cycles, then Monjuvi (tafasitamab-cxix) can be used as a single agent.		Licensed Practitioner	Plan Year Duration	
MONONINE					Licensed Practitioner	Plan Year Duration	
MOZOBIL		Treatment or prophylaxis of neutropenia or febrile neutropenia. Concomitant use with sargramostim or within seven	Autologous transplantation in patients with non-Hodgkin's Lymphoma (NHL) or Multiple Myeloma (MM): The member must have a diagnosis of non-Hodgkin's Lymphoma (NHL) or multiple myeloma (MM) AND Mozobil (plerixafor) must be used in combination with filgrastim, biosimilar filgrastim, or tbo-filgrastim AND		Licensed Practitioner	30 days. Mozobil will be approved for a 30-day interval once per	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		days of pegfilgrastim dose.Same day administration with myelosuppressive chemotherapy or radiation.Use beyond four consecutive days or use after completion of stem cell harvest/apheresis. Mozobil is not intended for stem cell mobilization and harvest in patients with leukemia.	Mozobil (plerixafor) must be a component of an autologous stem cell transplant mobilization protocol.			transplant.	
MVASI		Used in lung cancer members that have small cell or squamous cell	Metastatic colorectal cancer: Diagnosis of metastatic colorectal cancer AND one of the following apply: Member is using bevacizumab in combo with		Licensed Practitioner	6 Months Duration	Stage IV/Metastatic (Unresectable) RCC. Member has RCC and member is using bevacizumab to treat stage IV

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		disease, recent hemoptysis, history of bleeding, continuing anticoagulation, or as a single agent (unless maintenance as described in Coverage Determinations). Should not be initiated in members with recent hemoptysis. Should not be used in members who experience a severe arterial thromboembolic event. Should not be used in members with gastrointestinal perforation.	fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemotherapy for first or second-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line therapy in patients who have progressed on first-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). Member has NSCLC with non-squamous cell histology AND Member is using bevacizumab in combo with cisplatin or carboplatin based regimens for unresectable, locally advanced, recurrent, or metastatic NSCLC AND One of the following apply: using for first line therapy OR as subsequent therapy immediately after one of the following situations: EGFR mutation-positive tumors after prior therapy with erlotinib, afatinib, or gefitinib (if cytotoxic therapy not previously not given) OR ALK-positive tumors after prior therapy with crizotinib or ceritinib, or alectinib or brigatinib (if cytotoxic therapy not previously not				unresectable kidney cancer in combination with interferon alpha OR member is using bevacizumab as systemic therapy for non-clear cell histology. Recurrent Primary CNS Tumor (including Glioblastoma multiforme).The member has a diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND Bevacizumab is being used as a single agent or in combination with irinotecan, carmustine, lomustine or temozolomide. The member does not have a CNS hemorrhage. Cervical Cancer: The member has recurrent, or metastatic cervical cancer AND Bevacizumab will be used in combination (if not previously used as first line therapy) with paclitaxel and

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Bevacizumab should not be used in members with fistula formation involving internal organs. Bevacizumab should not be used in members experiencing a hypertensive crisis or hypertensive encephalopathy. Bevacizumab should not be used for at least 28 days following major surgery or until surgical incision is fully healed. Bevacizumab may not be used in conjunction with Vectibix. Bevacizumab may	given) OR ROS-1 positive disease after prior therapy with crizotinib (if cytotoxic therapy not previously not given) OR Pembrolizumab (with PD-L1 expression of greater than 1%) administered as first line therapy and EGFR, ALK, BRAF V600E, and ROS1 negative tumors (if cytotoxic therapy not previously not given) OR member has BRAF V600E positive disease OR member is using bevacizumab as single-agent continuation maintenance therapy if bevacizumab was used as first line treatment for recurrence or metastasis OR member has disease with no EGFR or ALK genomic tumor aberrations AND bevacizumab will be given in combo with carboplatin and paclitaxel and Tecentriq as first line therapy followed by maintenance therapy with combo Tecentriq and bevacizumab.				cisplatin or carboplatin and paclitaxel or paclitaxel and topotecan as first line therapy.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		not be used in conjunction with Erbitux. Bevacizumab may not be used in the adjuvant or neoadjuvant setting. Bevacizumab should not be continued or restarted after disease progression with the exception of metastatic colorectal cancer.					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MYALEPT		Partial lipodystrophy OR Liver disease including non-alcoholic steatohepatitis (NASH) OR HIV related lipodystophy OR Diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy OR Generalized obesity not associated with congenital leptin deficiency.	Congenital of Acquired Lipodystrophy: The member has a diagnosis of congenital OR acquired generalized lipodystrophy.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MYGLUCOHEALTH			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
MYLOTARG		Member has experienced disease progression on Mylotarg (gemtuzumab ozogamicin)	Acute Myelogenous Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has documented CD33-positive disease AND One of the following applies: The member has newly-diagnosed disease and is an adult OR The member has relapsed/refractory disease and is an adult or pediatric patient 2 years and older		Licensed Practitioner	Newly dx AML:6 months(max 1 cycle induction-8 cycles consolidation) Rel/Ref AML:3months(max 1 cycle)	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NAGLAZYME			Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome).The member must have a diagnosis of mucopolysaccharidosis VI (MPS VI,Maroteaux-Lamy syndrome).		Licensed Practitioner	Plan Year	
NATPARA		Patients with hypoparathyroidism caused by calcium-sensing receptor mutations.Patients with acute post-surgical hypoparathyroidism due to surgery within the past 4 months.	Hypocalcemia in patients with hypoparathyroidism: Member must have a diagnosis of hypocalcemia secondary to hypoparathyroidism		Licensed Practitioner	Plan Year Duration	
NERLYNX		Member has disease progression on Nerlynx (neratinib). Member is taking Nerlynx (neratinib)	Breast Cancer: Initial Therapy. The member has early stage (i.e. Stage I, II, III) documented HER2 + positive disease AND The member has completed adjuvant therapy with trastuzumab containing treatment [e.g. Herceptin (trastuzumab), Ogivri (trastuzumab-dkst), Herzuma		Licensed Practitioner	Initial therapy- 3 months. Continuation therapy- 9 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		total treatment for more than one year (applicable only to extended adjuvant setting).	(trastuzumab-pkrb), Ontruzant (trastuzumab-dttb), Trazimera (trastuzumab-qyyp)] AND Nerlynx (neratinib) is being used for the treatment in extended adjuvant setting AND The member is taking antidiarrheal prophylaxis (loperamide) concomitantly during the first two cycles. Continuation of therapy. The member is not experiencing any of the following situations: Grade 4 any adverse event [e.g., diarrhea, ALT (greater than 20 times ULN), bilirubin (greater than 10 times ULN)], Greater than or equal to grade 2 diarrhea with Nerlynx (neratinib dosing of 120mg per day AND If any of the above severe adverse reactions have been experienced, then provider has given a rationale for benefit of continued use that outweighs risk. Metastatic Breast Cancer: The member has metastatic or advanced breast cancer and all of the following apply: member has documented HER2 positive disease AND has received two or more prior anti-HER2 based regimens in the metastatic setting AND Nerlynx is				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			given in combination with capecitabine.				
NEULASTA		Concomitant use (within seven days of pegfilgrastim dose) with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrstim, or sargramostim.Same day administration with myelosuppressive chemotherapy or therapeutic radiation. (Note: Neulasta Onpro may be applied the same day as myelosuppressive chemotherapy.	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy. The patient must have a diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection. The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) is greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors), OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen AND one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or greater than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500		Licensed Practitioner	4 months duration	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy.) Cannot be given more than once per chemotherapy cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR Receiving a dose-dense chemotherapy regimen.				
NEULASTA ONPRO		Concomitant use (within seven days of pegfilgrastim dose) with	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy. The patient must have a diagnosis of non-		Licensed Practitioner	4 months duration	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrstim, or sargramostim.Same day administration with myelosuppressive chemotherapy or therapeutic radiation. (Note: Neulasta Onpro may be applied the same day as myelosuppressive chemotherapy. Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy.)	myeloid malignancy and has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection. The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) is greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors), OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen AND one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or greater than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age				myelosuppressive doses of nontherapeutic radiation.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Cannot be given more than once per chemotherapy cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR Receiving a dose-dense chemotherapy regimen.				
NEUPOGEN		Same day administration with myelosuppressive chemotherapy or therapeutic radiation.Concomitant use with tbo-filgratim, filgrastim,	Febrile Neutropenia Prophylaxis: In non-myeloid malignancies following myelosuppressive chemotherapy. The patient must have a diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy 24-72 hours prior to starting filgrastim injections. The member must also meet ONE OR MORE of the following criteria: A risk of febrile		Licensed Practitioner	4 months duration	Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, storing cells for a possible future autologous transplant, or donating stem cells for an allogeneic or syngeneic PBSC

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimilar pegfilgrastim (e.g. pegfilgrastim-jmdb or pegfilgrastim-cbqv, within seven days of pegfilgrastim dose).	neutropenia (FN) is greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors), OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen AND one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or greater than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR Receiving a dose-dense chemotherapy regimen. Febrile Neutropenia Prophylaxis,				transplant. Neutropenic disorder, chronic (Severe), Symptomatic. The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia.Neutropenia in Myelodysplastic Syndromes.The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome.Treatment of Febrile Neutropenia.The member must have a diagnosis of febrile neutropenia.Filgrastim must be used in adjunct with appropriate antibiotics in high risk patients. Neutropenia in AIDS patients.The member must have a diagnosis of AIDS with neutropenia.Treatment of Aplastic Anemia.The member must have a

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			In non-myeloid malignancies following progenitor-cell transplantation.The member must have had a peripheral-blood progenitor cell (PBPC)transplantation for a non-myeloid malignancy. Febrile Neutropenia Prophylaxis, In patients with acute myeloid leukemia receiving chemotherapy. The member must have a diagnosis Acute Myeloid Leukemia (AML).The member must be scheduled to receive either induction chemotherapy OR consolidation chemotherapy.				diagnosis of Aplastic Anemia.Treatment of Agranulocytosis.The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome. The member has been acutely exposed to myelosuppressive doses of radiation.
NEUTEK 2TEK TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NEXAVAR		Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Nexavar (sorafenib).	Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV) AND the member has experienced intolerance, contraindication, or unable to achieve treatment goals with Inlyta (axitinib) or Cabometyx (cabozantinib) as second line therapy (e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma AND Tumors are not responsive to radio-iodine treatment.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND The member experienced disease progression with imatinib or Sutent (sunitinib) or Stivarga (regorafenib).				
NINLARO		Concomitant use with proteasome inhibitors. Members with disease progression on Ninlaro (ixazomib).	Multiple Myeloma: second line. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least one prior therapy AND Ninlaro (ixazomib) will be used in combination with dexamethasone OR lenalidomide and dexamethasone OR cyclophosphamide and dexamethasone. Multiple Myeloma: third line or subsequent. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least two prior therapies including an immunomodulatory agent (e.g. lenalidomide) and a proteosome inhibitor (e.g. bortezomib) AND Ninlaro (ixazomib)		Licensed Practitioner	six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			will be used in combination with pomalidomide and dexamethasone AND The members has demonstrated disease progression on or within 60 days of completion of the last therapy. Multiple Myeloma (maintenance): The member has a diagnosis of multiple myeloma AND Ninlaro (ixazomib) will be used as monotherapy AND Ninlaro (ixazomib) will be used as maintenance therapy AND One of the following applies: after response to primary induction therapy OR after response or stable disease following autologous stem cell transplant.				
NIVESTYM		Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrastim, sargramostim (unless part of stem cell	Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia AND Nivestym (filgrastim-aafi) must be used in adjunct with appropriate antibiotics in high risk members. Febrile Neutropenia Prophylaxis, In non-myeloid		Licensed Practitioner	4 Months Duration (120 days)	Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimilar pegfilgrastim (e.g. pegfilgrastim-jmdb or pegfilgrastim-cbqv, within seven days of pegfilgrastim dose). Same day administration with myelosuppressive chemotherapy or therapeutic radiation.	malignancies following myelosuppressive chemotherapy: The member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to starting Nivestym (filgrastim-aafi) injections AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor,				consolidation Chemotherapy. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following Hematopoietic Stem Cell Transplant (HCST): The member must have had a Hematopoietic Stem Cell Transplant (HCST) (e.g. bone marrow transplant, peripheral-blood progenitor cell (PBPC) transplant) for a non-myeloid malignancy. Harvesting of peripheral blood stem cells: The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic,

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.				or idiopathic neutropenia.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NORTHERA			Neurogenic Orthostatic Hypotension: The member has symptomatic, neurogenic orthostatic hypotension (NOH) caused by: Primary autonomic failure- Parkinson's disease (PD), multiple system atrophy or pure autonomic failure OR Dopamine beta-hydroxylase deficiency OR Non-diabetic neuropathy. AND The member must have had previous treatment, intolerance, or contraindication to one of the following agents: fludrocortisone OR midodrine. Reauthorization Criteria: The member has experienced a positive clinical response with Northera use (e.g.,sustained decrease in dizziness).		Licensed Practitioner	Initial authorization approved for 3 months. Reauthorization approved in plan year duration.	
NORTRIPTYLINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NOVA MAX BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
NOVA MAX GLUCOSE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NOVOEIGHT					Licensed Practitioner	Plan Year Duration	
NOVOSEVEN RT					Licensed Practitioner	Plan Year Duration	
NOXAFIL		Coadministration with sirolimus,ergot alkaloids (ergotamine and dihydroergotamine), with CYP3A4 substrates terfenadine, astemizole, cisapride, pimozide, halofantrine, or quinidine can lead to QT prolongation and simvastatin.	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g.		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications.Treatment of Oropharyngeal or Esophageal Candidiasis.The member must have a diagnosis for orpharnygeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.				
NPLATE		Concomitant use with other platelet stimulating factors such as Promacta (eltrombopag) or Neumega (oprelvekin). Lack or loss of response (after four weeks at MAX dose), patient should be assessed for other possible etiologies	Chronic Idiopathic Thrombocytopenic Purpura. Initial Approval: Patient has a diagnosis of relapsed/refractory chronic (greater than 6 months) immune/idiopathic thrombocytopenic purpura (ITP) AND Patient has a platelet count of less than 50 (x 10(9)/L) AND Patient has had an insufficient response or is intolerant to corticosteroids or member has had a splenectomy with an inadequate response and an insufficient response to post-splenectomy corticosteroids. Reauthorizations: Patient		Licensed Practitioner	3 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(e.g., antibodies to romiplostim and bone marrow fibrosis) and romiplostim discontinued. ITP members with previous documented failure of Nplate (romiplostim).Members with hematological maglignancies or MDS.	has a platelet count of less than 400 x 10(9)/L AND Patient remains at risk for bleeding complications. Nplate should not be utilized to normalize platelet counts AND Patient is responding to therapy as evidenced by increased platelet counts.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
NUBEQA		Members that have experienced disease progression while on Nubeqa (darolutamide). Concomitant use with an androgen receptor inhibitor or androgen synthesis inhibitor (e.g. enzalutamide, abiraterone, nilutamide, flutamide, bicalutamide) due to lack of evidence supporting efficacy and safety.	Prostate Cancer (non-metastatic castration-resistant): The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND the member will use Nubeqa (darolutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog).		Licensed Practitioner	6 Months Duration	
NUCALA			Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			of greater than or equal to 150 cells/µL at therapy initiation OR greater than or equal to 300 cells/µL in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Continuation of therapy: Member is currently stable on therapy. Member will continue on asthma controller inhalers: inhaled corticosteroids with or without a long-acting beta2-agonist (e.g. Flovent HFA/Diskus, Arnuity Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicort HFA). Eosinophilic Granulomatosis with Polyangiitis (EGPA): The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), defined by a baseline elevated peripheral blood eosinophil level of greater than 1000 cells/µL, a diagnosis of asthma, AND two or more systemic				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			manifestations of EGPA. The member will be using Nucala (mepolizumab) for treatment of EGPA. The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone).				
NUEDEXTA		Concomitant use with MAO inhibitor or within 14 days of stopping MAO inhibitor prior to initial fill of Nuedexta. Concurrent use with drugs that prolong QT interval and are metabolized by CYP2D6 such as thioridazine or pimozide. Concurrent use with quinidine, quinine, or	Pseudobulbar Affect: The member must have a diagnosis of Pseudobulbar Affect (PBA) secondary to brain injury or underlying neurologic disease (e.g., stroke, multiple sclerosis, ALS, Parkinson's disease, traumatic brain injury) AND The member is experiencing characteristic behavior episodes (e.g inappropriate laughing or crying) consistent with PBA at baseline. Reauthorization: Documented improvement in inappropriate behavior episodes from baseline.	Member must be 18 years of age or older	Licensed Practitioner	Initial and Reauth: Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		mefloquine. Presense of prolonged QT interval, congenital long QT syndrome, heart failure, or history of torsades de pointes. Presense of AV block (complete or without a pacemaker).					
NUPLAZID		Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.	Parkinson's Disease Psychosis:The member is using Nuplazid for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.		Licensed Practitioner	Plan Year duration	
NUWIQ					Licensed Practitioner	Plan Year Duration	
OBIZUR					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OCTREOTIDE ACETATE			Acromegaly: The member must have a diagnosis of Acromegaly. Mmust have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have above grade 3 diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine.. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.				
ODOMZO		The member has experienced disease progression while on Odomzo.	Basal Cell Carcinoma:The member has a diagnosis of locally advanced or metastatic basal cell carcinoma AND The member has experienced recurrence or disease progression following surgery or radiation OR has a contraindication to surgery or radiation.		Licensed Practitioner	Six month duration	
OFEV		Clinically significant environmental exposure known to cause pulmonary fibrosis, including but not limited to	Idiopathic Pulmonary Fibrosis (IPF): The member has a diagnosis of idiopathic pulmonary fibrosis confirmed by one of the following: High-resolution computed tomography (HRCT) scan is indicative of usual interstitial pneumonia (UIP) OR A		Licensed Practitioner	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		drugs, asbestos, beryllium, radiation, and domestic birds (Esbriet requests only). Known explanation for interstitial lung disease, including but not limited to radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, and cancer (Esbriet requests only).	surgical lung biopsy. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) - Ofev (nintedanib) Requests only: The member will be taking Ofev (nintedanib) for a diagnosis of SSc-ILD confirmed by one of the following: High Resolution Computed Tomography (HRCT) with evidence of fibrosis OR Lung Biopsy AND Member does not have a previous or planned hematopoietic stem cell transplant AND Member does not have a diagnosis of Pulmonary Arterial Hypertension (WHO Group 1) requiring parenteral therapy with epoprostenol or treprostinil AND Member is not currently pregnant. Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype - Ofev (nintedanib) requests only: The member will be taking Ofev (nintedanib) for the diagnosis of a chronic fibrosing interstitial lung disease [ILD] (e.g., Hypersensitivity pneumonitis, Autoimmune ILD, Rheumatoid arthritis-associated ILD [RA-ILD], Mixed Connective Tissue Disease-associated ILD, Idiopathic				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			non-specific interstitial pneumonia, Unclassifiable Idiopathic Interstitial Pneumonia, Exposure-related ILDs, Sarcoidosis with Fibrosing ILD, or other chronic fibrosing ILDs) confirmed by one of the following: High Resolution Computer Tomography (HRCT) with evidence of fibrosis OR Lung Biopsy. Member has a progressive phenotype confirmed by one of the following: Has had a relative decline in FVC of at least 10% OR Worsening respiratory symptoms OR Increased extent of fibrotic change on HRCT. Member is not currently pregnant.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OGIVRI			For Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), or Ontruzant (trastuzumabdttb) requests: member must have an intolerance or contraindication Herceptin (trastuzumab) or Trazimera (trastuzumab–qyyp) or Kanjinti (trastuzumab-anns) and meets below criteria. Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease. Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.		Licensed Practitioner	6 months duration	
OMNITROPE		Pediatric growth hormone discontinuation. Increase in height velocity is less than 2 cm total growth in one year of	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A		Licensed Practitioner	Plan Year Duration	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		therapy: OR Final adult height has been achieved (member's calculated mid-parental height).The epiphyses have closed. Constitutional delay of growth and development. Skeletal dysplasias (e.g., achondroplasia, kyphomelic dysplasia). Osteogenesis imperfect. "Somatopause" in older adults.Infertility. Burn injuries. Obesity/morbid obesity.	subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, GHRH+ARG,glucagon, macimorelin test, and ARG. If ITT is not desirable and when recombinant GHRH is not available, the glucagon test is alternative, but not levodopa/clonidine tests. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is less than or equal to 3ng/ml and to arginine stimulation test is less than or equal to 4ng/ml. Subnormal response to the macimorelin test is less than or equal to 2.8 mcg/L. Subnormal response to GHRH+ARG is: less than or equal to 11 ng/ml in members with a BMI less than 25kg/m2, less than or equal to 8 ng/ml in members with a BMI greater than or equal				rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex.Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Hypophosphatemia (hypophosphatemic rickets). Muscular dystrophy. Cystic fibrosis. Spina bifida. Juvenile rheumatoid arthritis. Osteoporosis. Post-traumatic stress disorder. Depression. Hypertension. Corticosteroid-induced pituitary ablation. Precocious puberty. Chronic fatigue syndrome. Crohn's disease . Anti-aging . Growth retardation due to	to 25 and less than 30kg/m2, less than or equal to 4 ng/ml in members with a BMI greater than 30kg/m2. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Members with irreversible hypothalamic-pituitary structural lesions and those with evidence of panhypopituitarism and serum IGF-I levels below the age, sex appropriate reference range when off GH therapy are GH deficient.				retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex).Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		amphetamines. Chronic catabolic states, including respiratory failure, pharmacologic glucocorticoid administration, and inflammatory bowel disease. Down syndrome and other syndromes associated with short stature and increased susceptibility to neoplasms (Bloom syndrome, Fanconi syndrome).					growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							impairment . Noonan Syndrome.Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex. Pediatric GH discontinuation warranted when Increase in height velocity is less than 2 cm total growth in 1 year of therapy: OR Final adult height has been achieved (member's calculated mid-parental height): The epiphyses have closed.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ON CALL EXPRESS METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ON CALL EXPRESS TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ON CALL PLUS METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ON CALL PLUS TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ON CALL VIVID METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ON CALL VIVID PAL METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ON CALL VIVID TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONCASPAR		Members that have experienced disease progression while on or following Oncaspar. Members with a history of serious thrombosis with prior asparaginase therapy. Members with a history of pancreatitis with prior asparaginase therapy. Members with a history of serious hemorrhagic events with prior asparaginase therapy. Members with total bilirubin more than 10 times the upper limit of normal.	Acute Lymphoblastic Leukemia: The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member will be using Oncaspar (pegaspargase) as a component of a multi-agent chemotherapy regimen.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONETOUCH ULTRA BLUE TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ONETOUCH ULTRA2 METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONETOUCH ULTRAMINI			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ONETOUCH VERIO FLEX METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONETOUCH VERIO FLEX START			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ONETOUCH VERIO IQ METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONETOUCH VERIO METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ONETOUCH VERIO REFLECT METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONETOUCH VERIO REFLECT START			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ONETOUCH VERIO TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONIVYDE		Monotherapy with Onivyde (liposomal irinotecan). Members that have experienced disease progression while on Onivyde (liposomal irinotecan).	Pancreatic Cancer: The member has a diagnosis of metastatic adenocarcinoma of the pancreas.The member has previously received gemcitabine based therapy or fluoropyrimidine based therapy (not including irinotecan) and experienced disease progression. The member will be using Onivyde (liposomal irinotecan) in combination with fluorouracil and leucovorin.		Licensed Practitioner	6 months duration	
ONUREG		The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).	Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia AND The member is using Onureg (azacitidine) for post-remission therapy AND The member has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND The member is not able to complete or declines intensive curative therapy (e.g. allogeneic hematopoietic stem cell transplant) AND The member will use Onureg (azacitidine) as a single agent.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OPDIVO		Disease progression while on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]). Adjuvant melanoma only: member is taking Opdivo (nivolumab) total treatment for more than one year.	Melanoma: The member must have a diagnosis of unresectable or metastatic melanoma AND the member will be using Opdivo (nivolumab) in combination with Yervoy (ipilimumab) OR the member will be using Opdivo as monotherapy. Melanoma-Adjuvant: The member has a diagnosis of stage III or stage IV melanoma AND the member has undergone complete resection of disease AND the member will be using Opdivo as adjuvant treatment AND the member will be using Opdivo as monotherapy. Non-Small Cell Lung Cancer-subsequent therapy: The member must have a diagnosis of metastatic squamous or non-squamous NSCLC AND The member has experienced disease progression on or after chemotherapy and EGFR inhibitor (e.g.,Tarceva [erlotinib], Iressa [gefitinib], Gilotrif [afatinib]), if EGFR mutation positive or ALK inhibitor (e.g., Xalkori (crizotinib)), if ALK positive AND The member will be using Opdivo as monotherapy. Renal Cell Carcinoma (RCC):		Licensed Practitioner	6 months duration	Squamous Cell Carcinoma of the Head and Neck (SCCHN): The member has a diagnosis of non-nasopharyngeal recurrent or metastatic squamous cell carcinoma of the head and neck AND the member will be using Opdivo (nivolumab) as monotherapy AND the member has disease progression on or after platinum based therapy. Small Cell Lung Cancer: The member has a diagnosis of small cell lung cancer (SCLC) AND the member will be using Opdivo (nivolumab) for subsequent therapy AND the member will be using Opdivo (nivolumab) as monotherapy or in combination with Yervoy (ipilimumab) for one of the following: Disease relapse within 6 months following complete response, partial

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			The member has a diagnosis of advanced RCC AND The member will be using Opdivo as monotherapy AND one of the following applies: the member has predominant clear cell histology and will be using Opdivo as subsequent therapy OR the member has non-clear cell histology OR The member will be using Opdivo in combination with Yervoy AND has intermediate or poor risk disease, based on International Metastatic Renal Cell Carcinoma Database Consortium Criteria AND has predominant clear cell histology AND will be using for first line therapy. Classical Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin Lymphoma AND The member has relapsed or refractory disease AND The member will be using Opdivo as monotherapy AND The member will be using as third-line or subsequent therapy AND One of the following criteria applies: The member will be using Opdivo following autologous stem cell transplant OR The member is transplant ineligible				response, or stable disease with initial treatment OR Progressive disease. Urothelial Cancer: Diagnosis of locally advanced or metastatic urothelial cancer AND will use Opdivo (nivolumab) as monotherapy AND One of the following apply: Will be use Opdivo (nivolumab) as a second or subsequent line-therapy OR Disease progression within 12 months of neoadjuvant or adjuvant chemotherapy Hepatocellular Carcinoma. The member has a diagnosis of hepatocellular carcinoma AND the member has been previously treated with Nexavar (sorafenib) AND the member will be using Opdivo (nivolumab) as monotherapy or in combination with Yervoy. Microsatellite

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(based on comorbidity or failure of second-line chemotherapy) OR The member will be using post-allogeneic transplant.				Instability-High (MSI-H) or Mistmatch Repair Deficient (dMMR) Metastatic Colorectal Cancer. The member has a diagnosis of unresectable or metastatic colorectal cancer with documented MSI-H or dMMR AND the member will be using Opdivo (nivolumab) as monotherapy or in combination with ipilimumab AND one of the following applies: the member has disease that has progressed following treatment with oxaliplatin-, irinotecan-, or fluoropyrimidine-based therapy OR the member has unresectable metachronous metastases and previously received adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin)

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							within the past 12 months. Non-small cell lung cancer (NSCLC) -- First Line Therapy: The member must have a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND one of the following applies: Disease with PD-L1 expression greater than or equal to 1% with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Tumor expresses PD-L1 as determined by an FDA-approved test AND Will be used in combination with Yervoy (ipilimumab) OR Disease with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Will be used in combination with Yervoy (ipilimumab) AND Will be used in combination with two

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							cycles of platinum doublet chemotherapy. Esophageal cancer: The member has unresectable advanced, recurrent or metastatic squamous cell carcinoma of the esophagus AND The disease progressed after prior fluoropyrimidine- and platinum-based chemotherapy AND Opdivo (nivolumab) will be given subsequent therapy as a single agent.
OPSUMIT		The member is concomitantly taking endothelin receptor antagonist (e.g., Letairis, Tracleer).	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OPTIUM EZ			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
OPTIUM TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OPTUMRX			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ORKAMBI			Cystic Fibrosis:The member has a diagnosis of Cystic Fibrosis.The member has documentation of a homozygous F508del mutation in the CFTR gene.	Member is 2 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OSPHENA		Undiagnosed abnormal genital bleeding. Known or suspected estrogen dependent neoplasia, OR Active DVT, pulmonary embolism (PE), or a history of these conditions, OR Active arterial thromboembolic disease (e.g. stroke and myocardial infarction or a history of these conditions).	The member must be a post-menopausal woman AND the member must have vulvar and/or vaginal atrophy AND the member must have moderate to severe dyspareunia. Treatment of moderate to severe vaginal dryness: The member must have moderate to severe vaginal dryness.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
OXANDROLONE		Enhancement of athletic performance.	Oxandrolone will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Cachexia associated with AIDS wasting syndrome: weight loss from cancer chemotherapy, severe burns, spinal cord injury, Corticosteroid-induced protein catabolism, Symptomatic treatment of bone pain accompanying osteoporosis, Alcoholic hepatitis, Turner Syndrome, Constitutional delay in growth and puberty, Duchenne muscular dystrophy.		Licensed Practitioner	Plan Year Duration	
OZURDEX		Advanced glaucoma. Aphakic Eyes with Rupture of the Posterior Lens Capsule. ACIOL (Anterior Chamber intraocular Lens)and Rupture of the Posterior Lens Capsule.	Macular Edema resulting in Ocular Inflammation following Branch Retinal Vein Occlusion (BRVO) or Central vein occlusion (CRVO): Patient has diagnosis of Macular Edema due to BRVO or CRVO. Patient has diagnosis of Non-infectious Posterior Segment Uveitis.Diabetic Macular Edema:Member has a diagnosis of diabetic macular edema.		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PADCEV			Bladder Cancer. The member has locally advanced or metastatic bladder cancer AND The member has received prior treatment with a platinum-containing chemotherapy AND The member has received previous treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PALIPERIDONE		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Bipolar Disorder, Acute Manic and Mixed Episodes:The member must have a diagnosis of bipolar disorder (acute manic and mixed episodes). The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Schizophrenia: The member must have a diagnosis of schizophrenia. The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Schizoaffective Disorder: The member must have a diagnosis of schizoaffective disorder. The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.	Age 18 or older for Bipolar Disorder, Acute Manic and Mixed Episodes and for Schizoaffective Disorder and age 12 or older for Schizophrenia.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PAROXETINE HCL			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
PAXIL			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PEMAZYRE		Member experienced disease progression on Pemazyre (pemigatinib).	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic cholangiocarcinoma and the disease is fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test and the member has received prior treatment and Pemazyre (pemigatinib) is given as a single agent for subsequent therapy.		Licensed Practitioner	Six months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PERFOROMIST		Concurrent use with other medications containing Long-acting beta2-adrenergic agonists. Initiation during acute deteriorations of COPD. Asthma, in the absence of concurrent medication containing inhaled corticosteroid and comorbid COPD diagnosis.	Chronic Obstructive Pulmonary Disease (COPD).Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema, requiring maintenance treatment of bronchoconstriction.		Licensed Practitioner	Plan year duration	
PERJETA		Member exceeds a total treatment of 52 weeks or 18 treatment cycles (applicable to neoadjuvant and/or adjuvant	Metastatic Breast Cancer. Diagnosis of metastatic breast cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease AND one of the following applies: will be receiving Perjeta (pertuzumab) in		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		treatment).	combination with trastuzumab product and docetaxel or paclitaxel and has not received prior anti-HER2 therapy or chemotherapy for metastatic disease OR the member has received prior cytotoxic therapy with or without trastuzumab product for second or subsequent line of therapy. Early Stage Breast Cancer. The member has a diagnosis of locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) and HER2 positive disease AND Perjeta (pertuzumab) will be used as neoadjuvant treatment as part of a complete treatment regimen and one of the following applies: in combination with trastuzumab product and docetaxel or paclitaxel (after completion of combination of doxorubicin plus cyclophosphamide regimen) or in combination with TCH (docetaxel, carboplatin, and trastuzumab product) OR The member has a diagnosis of early stage HER2 positive breast cancer at high risk of				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			recurrence (e.g., node positive disease, hormone receptor negative, T2 non-metastatic disease) AND Perjeta (pertuzumab) will be used as adjuvant therapy and one of the following applies: combination with trastuzumab product and paclitaxel or docetaxel (following doxorubicin plus cyclophosphamide regimen) or docetaxel plus carboplatin.				
PERPHENAZINE-AMITRIPTYLINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PHARMACIST CHOICE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PHARMACIST CHOICE GLUCOSE SYS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PIQRAY		Members have severe hypersensitivity to Piqray (alpelisib). Members has experienced disease progression on PIK3CA inhibitors (e.g., alpelisib).	Breast Cancer: The member has a diagnosis of advanced or metastatic hormone receptor positive, human epidermal growth factor receptor 2 (HER 2) negative breast cancer and PIK3CA mutated as detected by FDA approved test AND the member has experienced disease progression on or after endocrine based therapy within one year (e.g., anastrozole, palbociclib) AND Piqray (alpelisib) will be given in combination with fulvestrant as subsequent therapy.		Licensed Practitioner	Plan Year Duration	
POLIVY		Member has experienced disease progression on Polivy (polatuzumab vedotin-piiq). The member has baseline Grade 2 or higher peripheral neuropathy. The member has active	Diffuse large B-cell lymphoma: the member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma AND the member has received at least two prior lines of therapy AND the member will be using in combination with bendamustine and a rituximab product.		Licensed Practitioner	12 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		central nervous system lymphoma. The member has transformation from indolent lymphoma (e.g. follicular lymphoma) info diffuse large B-cell lymphoma. The member has received prior allogeneic hematopoietic stem cell transplant (HSCT).					
POMALYST		Members receiving concomitant therapy with an immunomodulator. The member has experienced disease progression while	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member has received at least two previous regimens AND The member has demonstrated disease progression while on Revlimid (lenalidomide) OR Thalomid (thalidomide) AND The member demonstrated disease progression while		Licensed Practitioner	Six months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on Pomalyst (pomalidomide).	on a protease inhibitor (e.g. bortezomib, carflizomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen [does not apply to requests for combination with Darzalex (daratumumab) plus dexamethasone or elotuzumab plus dexamethasone] AND The member will be using Pomalyst in one of the following regimens: in combination with dexamethasone and daratumumab, with dexamethasone and elotuzumab, with dexamethasone and ixazomib, with dexamethasone and cyclophosphamide, with dexamethasone, with dexamethasone and bortezomib, with dexamethasone and carfilzomib, or as a single agent (for steroid-intolerant patients). Kaposi Sarcoma: The member has a diagnosis of AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy OR The member has a diagnosis of Kaposi sarcoma that is HIV-negative.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PORTRAZZA		The member has experienced disease progression while on Portrazza (necitumumab).	Non-Small Cell Lung Cancer:The member has a diagnosis of metastatic squamous non-small cell lung cancer AND The member will be initially using Portrazza (necitumumab) in combination with gemcitabine and cisplatin AND The member will be using Portrazza (necitumumab) as first-line treatment.		Licensed Practitioner	six month duration	
POSACONAZOLE		Coadministration with sirolimus,ergot alkaloids (ergotamine and dihydroergotamine), with CYP3A4 substrates terfenadine, astemizole, cisapride, pimozide, halofantrine, or quinidine can lead to QT prolongation and simvastatin.	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g. voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications.Treatment of Oropharyngeal or Esophageal Candidiasis.The member must have a diagnosis for orpharnygeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.				
POTELIGEO		Member has experienced disease progression while on or following Poteligeo (mogamulizumab-kpkc).	Sézary syndrome AND The member has relapsed or refractory disease AND The member will be using Poteligeo (mogamulizumab-kpkc) as the sole systemic therapy.		Licensed Practitioner	6 Months Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRECISION			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRECISION PCX PLUS TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRECISION PCX TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRECISION POINT OF CARE TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRECISION Q-I-D TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRECISION XTRA KETONE-GLUCOSE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRECISION XTRA MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRECISION XTRA TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PREMIER BLU GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PREMIER COMPACT GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PREMIER TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PREMIER VOICE GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PREMIUM BLOOD GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PREMIUM V10			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRESTO PRO BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRIALT		Pre-existing history of psychosis. Contraindications to IT analgesia including: The presence of infection at the microinfusion injection site, Uncontrolled bleeding diathesis, Spinal canal obstruction.	Severe chronic pain: Intrathecal therapy for the treatment of severe chronic pain is warranted. Member must be intolerant of or refractory to other treatment, such as systemic analgesics, adjunctive therapies, or intrathecal (IT) morphine.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRO VOICE V8 GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRO VOICE V8-V9 TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRO VOICE V9 GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PROBUPHINE		Concurrent use of methadone. Concurrent use of ANY narcotic medication used to treat pain.	Maintenance Treatment of Opioid Dependence: Member must have achieved and have currently sustained prolonged clinical stability on 8mg or less per day of buprenorphine.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRODIGY AUTOCODE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRODIGY AUTOCODE MONITOR SYST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRODIGY NO CODING			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PRODIGY POCKET METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PRODIGY VOICE GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
PROFILNINE					Licensed Practitioner	Plan Year Duration	
PROMACTA		Concomitant use with other platelet stimulating factors such as Nplate (romiplostim) or Neumega (oprelvekin). ITP members with previous documented failure of	Chronic Idiopathic Thrombocytopenic Purpura. Initial Approval:The member has a diagnosis of relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) AND The member has a platelet count of less than 50 x 109/L. The member has had an insufficient response or is intolerant to corticosteroids OR The member has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		eltrombopag.	post-splenectomy corticosteroids. Reauthorizations. The member has a platelet count of less than 400 x 109/L AND The member remains at risk for bleeding complications AND The member is responding to therapy as evidenced by increased platelet counts. Thrombocytopenia in Patients with Hepatitis C Infection: Initial Approval: The member has a diagnosis of chronic hepatitis C. The member has a platelet count of less than 75 x 109/L. The degree of thrombocytopenia is preventing the initiation of interferon therapy OR limits the ability to maintain optimal interferon based therapy. Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts AND The member continues to receive interferon based therapy. Aplastic Anemia:Initial Approval:The member has a diagnosis of aplastic anemia AND The member will receive Promacta (eltrombopag) in				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			combination with immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin) for first-line treatment of severe aplastic anemia OR Promacta (eltrombopag) is being used for the treatment of refractory severe aplastic anemia in members with an insufficient response to immunosuppresive therapy (e.g. cyclosporine, antithymocyte immune globulin). Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts.				
PROMETHAZINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PROTRIPTYLINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
PROVENGE		Stage I-III Prostate Cancer.Concomitant use with Zytiga(abiraterone acetate)or Xtandi (enzalutamide).	Provenge (sipuleucel-T) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Prostate Cancer. The member has asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone-refractory) prostate cancer AND Member has ECOG performance status 0-1 AND Member does not have visceral disease (lung, liver, brain metastases)		Licensed Practitioner	15 weeks	
QINLOCK		Member experiences disease progression on Qinlock.	GIST. The member has a diagnosis of advanced GIST AND The member has received prior therapy with three or more kinase inhibitors, including imatinib AND Qinlock is being used as monotherapy.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
QUININE SULFATE		Prolongation of QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.	Plasmodium Falciparum Malaria: Diagnosis of uncomplicated chloroquine-resistant Plasmodium falciparum malaria. Brand Qualaquin request only: Members must have had previous treatment with generic Qualaquin(Quinine)or who have had contraindications or intolerance with generic Qualaquin(Quinine).		Licensed Practitioner	Plan Year Duration	
QUINTET AC			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
QUINTET BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
QUINTET GLUCOSE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
REBINYN					Licensed Practitioner	Plan Year Duration	
RECOMBINATE					Licensed Practitioner	Plan Year Duration	
REFUAH PLUS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
REFUAH PLUS GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RELION ALL-IN-ONE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RELION CONFIRM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RELION CONFIRM-MICRO			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RELION MICRO GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RELION PRIME METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RELION PRIME TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RELION ULTIMA			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
REMDESIVIR			The member must have a confirmed diagnosis of COVID-19 AND The member must be hospitalized or in a healthcare setting capable of providing acute care comparable to inpatient hospital care* AND Veklury will not be coadministered with chloroquine phosphate or hydroxychloroquine sulfate AND The member must have ALL of the following laboratory testing prior to therapy initiation and during therapy as clinically appropriate: Renal (eGFR). *Skilled nursing facilities, long-term care facilities, or other similar healthcare settings are not considered capable of providing acute care comparable to inpatient hospital care (per the Summary Review of the NDA by the FDA).	The member must be 12 years of age or older and weigh at least 40 kg (88 lbs).	Licensed Practitioner	Up to 28 days or as determined through clinical review.	
REPATHA PUSHTRONEX			Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal	Member must be 18 years of age or older for diagnosis of Heterozygous Familial Hypercholesterolemia or Clinical	Licensed Practitioner	Primary Hyperlipidemia and ACSVD: Initial Auth 6	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin. Reauthorization: maintenance of a reduction in LDL-C from baseline.	Atherosclerotic Cardiovascular Disease		months. Reauth: Plan Year. HOFH: Plan Year.	syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							attempting a different statin. Reauthorization: Maintenance of a reduction in LDL-C from baseline. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
REPATHA SURECLICK			Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR	Member must be 18 years of age or older for diagnosis of Heterozygous Familial Hypercholesterolemia or Clinical Atherosclerotic Cardiovascular Disease	Licensed Practitioner	Primary Hyperlipidemia and ACSVD: Initial Auth 6 months. Reauth: Plan Year. HOFH:	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin. Reauthorization: maintenance of a reduction in LDL-C from baseline.			Plan Year.	revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and attempting a different statin. Reauthorization: Maintenance of a reduction in LDL-C from baseline.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
REPATHA SYRINGE			Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin.	Member must be 18 years of age or older for diagnosis of Heterozygous Familial Hypercholesterolemia or Clinical Atherosclerotic Cardiovascular Disease	Licensed Practitioner	Primary Hyperlipidemia and ACSVD: Initial Auth 6 months. Reauth: Plan Year. HOFH: Plan Year.	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Reauthorization: maintenance of a reduction in LDL-C from baseline.				origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and attempting a different statin. Reauthorization: Maintenance of a reduction in LDL-C from baseline. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							(evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
RETACRIT		Concomitant use of another Recombinant Erythropoietin Product.	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL. Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than		Licensed Practitioner	3 months for chemo induced anemia,HIV,HCV,RA, MDS,surgery. 6 months for CKD, CKD reauth: Plan Year.	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: Diagnosis of symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than or

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer -first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks. Must have had a response of no less than 1 g/dL increase in Hgb levels in any prior use of epoetin therapy—can't be a documented failure on previous epoetin therapy with a similar myelosuppressive chemotherapy regimen. Must meet ALL of the following criteria: Current-within the last 4 weeks Hgb level				equal to 10.0 g/dL or HCT less than 30 (within last 4 weeks). Member is receiving iron therapy if indicated. Continue Therapy: Has attained a response defined as a 1 g/dl rise in Hgb (not to exceed 12g/dl) or a decrease in RBC transfusion requirement. Anemia associated with Management of Hepatitis C. Diagnosis of anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above(within the last 4 weeks).Continue Therapy: Must be receiving

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			is low enough to necessitate transfusion (and Hgb is less than 10 g/dL). Member has received iron therapy if indicated. Epoetin should be stopped if after six-eight weeks the member has not experienced a greater than or equal 1 g/dL rise in Hgb. Epoetin should not be continued after completion of myelosuppressive chemotherapy.				combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA)Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30(within the last 4 weeks).Continue Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Continuation of therapy requires documented Transferrin saturation of at least 20% OR

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							ferritin of at least 100 ng/ mL within the last 4 months for all indications (applies to most recent result).
RETEVMO		Member experiences disease progression on Retevmo.	Non-small cell lung cancer. The member has a diagnosis of metastatic non-small lung cancer AND The disease is documented RET fusion positive AND Retevmo is being used as monotherapy. Medullary Thyroid cancer. The member has a diagnosis of metastatic or advanced medullary thyroid cancer AND The disease is documented RET mutant AND Retevmo is being used as a single agent for systemic therapy. Thyroid cancer. The member has a diagnosis of metastatic or advanced thyroid cancer AND The disease is documented RET fusion positive AND The disease is radioactive iodine refractory AND Retevmo is being used as a single agent for systemic therapy.	For medullary thyroid cancer and thyroid cancer only: the member is 12 years and older.	Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RETISERT		Active ocular or periocular infections. Advanced Glaucoma (e.g. cup to disc ratio of greater than 0.8).	Chronic Non-infectious Uveitis: Member has a diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye. Member has had previous treatment with at least a 28 day course of a systemic immunosupressive agent and did not have a clinically meaningful improvement in symptoms.		Licensed Practitioner	Plan year duration	
REVEAL BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
REVEAL TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
REVLIMID		Members on concomitant Thalomid (thalidomide) or Pomalyst (pomalidomide).Members that have experienced disease progression while on Revlimid (lenalidomide).	Myelodysplastic Syndromes (MDS) with 5Q deletion. The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has transfusion dependent anemia ('transfusion dependent' for initial approval) AND the member has a documented deletion 5q chromosomal abnormality. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND		Licensed Practitioner	6 months duration	Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease OR the member will be using as palliative therapy for older adults (age greater than 60). Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			The member has transfusion dependent anemia ('transfusion dependent' for initial approval) without 5q deletion abnormality AND One of the following applies: Serum erythropoietin levels greater than 500 mU/ml, AND the member has had a trial with or has a low probability of response to immunosuppressive therapy (e.g. ATG or cyclosporine) OR Serum erythropoietin levels less than or equal to 500mU/ml AND had a trial with, contraindication, or intolerance to epoetin alfa or darbepoetin. Multiple Myeloma. Diagnosis of active Multiple Myeloma or Systemic Light Chain Amyloidosis. Primary induction OR for relapsed/refractory disease, Revlimid (lenalidomide) therapy should be utilized in conjunction with dexamethasone if no contraindication. As maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation. For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via				lymphoma, follicular lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], primary cutaneous B-cell lymphoma, or marginal zone lymphoma AND The member has relapsed or refractory disease.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			no evidence of disease progression/treatment failure. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL). For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression. Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND the member has relapsed, refractory or progressive disease.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
REXULTI		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Major depressive disorder:The member must have clinically diagnosed major depressive disorder AND The member must have documentation of prior therapy, intolerance, or contraindication to aripiprazole AND at least one antidepressant therapy (ADT) AND Rexulti must be used as adjunctive or add-on treatment to ADT and not as monotherapy. Schizophrenia:The member must have clinically diagnosed schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to aripiprazole AND one of the following: risperidone or olanzapine or quetiapine or ziprasidone.	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RIGHTEST GM250S GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RIGHTEST GM260 GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RIGHTEST GM550 SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RIGHTEST GS250S TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RIGHTEST GS260 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
RIGHTEST GS550 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RINVOQ		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade), JAK inhibitors (e.g. Xeljanz, Olumiant) or potent immunosuppressants (e.g. azathioprine, cyclosporine).	Rheumatoid Arthritis: The member has a diagnosis of moderate to severely active rheumatoid arthritis AND the member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide), or contraindication to all DMARDs	The member is 18 years of age or older.	Licensed Practitioner	Plan Year Duration	
RITUXAN		High dose CLL therapies (doses greater than 500mg/m^2). The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The	For requests for Truxima: member must have intolerance or contraindication with Rituxan (rituximab) or Ruxience (rituximab-pvvr). Truxima and Ruxience requests are only for NHL, CLL, RA, granulomatosis with polyangitis (GPA) (Wegener’s Granulomatosis), and microscopic polyangitis (MPA). Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin’s Lymphoma (CD-20 positive/B-Cell). The	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.	Licensed Practitioner	Plan Year Duration	The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder.The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).	member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with: Remicade OR Inflectra AND Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab therapy, unless contraindicated or intolerant to methotrexate.				diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER:Platelet count less than 25,000/µL OR Active bleeding due to inadequate platelet function.The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							months.Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
RITUXAN HYCELA		The member will be using Rituxan Hycela (rituximab/hyaluronidase) for the treatment of a non-malignant condition (e.g. rheumatoid arthritis). The member will be using Rituxan Hycela (rituximab/hyaluro	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member will be using Rituxan Hycela as monotherapy or in combination with fludarabine and cyclophosphamide. Follicular lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following applies: Previously untreated disease and will be using Rituxan Hycela in combination with first line chemotherapy and, in patients achieving a complete or partial response to Rituxan Hycela in combination with		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		nidase) as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The member will be using Rituxan Hycela (rituximab/hyaluronidase) as a single agent for first-line therapy in follicular lymphoma (FL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).	chemotherapy, as single-agent maintenance therapy OR Non-progressing (including stable disease) disease, as a single agent after first line cyclophosphamide, vincristine, and prednisone chemotherapy OR Relapsed or refractory disease, as a single agent. Diffuse large B cell lymphoma: The member has a diagnosis of diffuse large B cell lymphoma AND The member has previously untreated disease and will be using Rituxan Hycela in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone or with another anthracycline-based chemotherapy regimen. For all indications: The member is unable to achieve treatment goals with Rituxan (rituximab) or Ruxience (rituximab-pvvr) and meets the clinical criteria.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RIXUBIS					Licensed Practitioner	Plan Year Duration	
ROMIDEPSIN		Members that have experienced disease progression while on romidepsin.Members on concomitant hypomethylator (e.g. vorinostat) therapy.	Cutaneous T-cell Lymphoma (CTCL). Istodax (romidepsin) is being used to treat cutaneous T-cell lymphoma AND one of the following applies: the member will be using Istodax (romidepsin) as primary biologic systemic therapy OR the member will be using Istodax (romidepsin) as adjuvant systemic biologic therapy OR the member has received at least one prior therapy. Peripheral T-cell Lymphoma (PTCL).Istodax (romidepsin) is being used to treat relapsed or refractory peripheral T-cell lymphoma. The member has received at least one prior therapy.		Licensed Practitioner.	6 month duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ROZLYTREK			Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the member has disease which is ROS1-positive. Solid Tumors: the member has a diagnosis of solid tumors which are metastatic AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation AND The member is not a candidate for surgical resection AND The member's disease has progressed following treatment or does not have satisfactory alternative therapy options. Reauthorization: The member has not developed a known resistance to Rozlytrek (entrectinib) AND Physician attestation that the member has continued to receive a clinical benefit (e.g., complete response, partial response, stable disease) and has not experienced disease progression.	Solid tumors: member is 12 years of age or older.	Licensed Practitioner	Plan Year Duration	
RUBRACA		Members that	Ovarian Cancer Maintenance Therapy: The		Licensed	6 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		have experienced disease progression while on PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula(niraparib)].	member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Rubraca (rucaparib) as monotherapy. *Discontinue Avasatin before initiating maintenance therapy with Rubraca. BRCA-Mutated Advanced Ovarian Cancer:The member has a diagnosis of advanced ovarian cancer AND The member has deleterious BRCA mutation (germline and/or somatic) AND The member has been treated with two or more prior lines of chemotherapy AND The member will utilize Rubraca (rucaparib) as a monotherapy. Metastatic Castration-Resistant Prostate Cancer: The member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND The member has documented deleterious BRCA mutation		Practitioner.	duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(germline and/or somatic) AND The member has had prior treatment with androgen receptor-directed therapy (e.g. abiraterone, Xtandi, Erleada, or Nubeqa) and a taxane-based chemotherapy (e.g. docetaxel) AND The member will use Rubraca (rucaparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RUCONEST		Use for prophylaxis of HAE attack. Evidence of autoantibodies against the C1INH protein. Evidence of underlying lymphoproliferative, malignant, or autoimmune disorder that causes angioedema attacks. Use in combination with other agents approved for acute treatment of HAE attack (e.g. Berinert, Firazyr, Kalbitor).	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Low evidence of C4 level (less than 14 mg/dL) AND Low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (functional C1INH less than 50%) OR Known HAE-causing C1INH mutation. The member is using Ruconest for the treatment of acute attacks of HAE.	Must be 13 years or older.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
RUFINAMIDE		Patients with familial short QT syndrome.	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND the member has prior therapy with, contraindication or intolerance to at least two other drugs indicated for LGS (e.g., topiramate, lamotrogine).	Member is one year of age or older.	Licensed Practitioner.	Plan Year Duration	
RUXIENCE		High dose CLL therapies (doses greater than 500mg/m^2). The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g.	For requests for Truxima: member must have intolerance or contraindication with Rituxan (rituximab) or Ruxience (rituximab-pvvr). Truxima and Ruxience requests are only for NHL, CLL, RA, granulomatosis with polyangitis (GPA) (Wegener's Granulomatosis), and microscopic polyangitis (MPA). Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab for primary treatment or for	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.	Licensed Practitioner	Plan Year Duration	The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder.The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		follicular lymphoma, marginal zone lymphoma).	relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with: Remicade OR Inflectra AND Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab therapy, unless contraindicated or intolerant to methotrexate.				intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER:Platelet count less than 25,000/µL OR Active bleeding due to inadequate platelet function.The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months.Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab in combination with glucocorticoids. Pemphigus

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
RUZURGI		History of seizures.	Lambert-Eaton Myasthenic Syndrome (LEMS): The member has a confirmed diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) by a specialist (e.g. neurologist) AND The diagnosis is supported by results from a clinical evaluation (e.g. electromyography or the presence of autoantibodies directed against VGCC [voltage gated calcium channels]).	The member is 6 years of age or older.	Licensed Practitioner	Plan Year Duration	
RYDAPT		Members that have experienced disease progression while on or following Rydapt (midostaurin), Members with a diagnosis of therapy-related	Acute Myeloid Leukemia: The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Systemic Mastocytosis: The member has a diagnosis of aggressive		Licensed Practitioner.	6 Months Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		acute myeloid leukemia (defined as acute myeloid leukemia due to prior radiation therapy or prior chemotherapy used as therapy for a prior disorder or malignancy), Members with a diagnosis of acute promyelocytic leukemia (APL), Members that are using Rydapt(midostaurin) for post-consolidation therapy, Members that are using Rydapt (midostaurin) as a single agent induction therapy	systemic mastocytosis (ASM), systemic mastocytosis with associated hematologic neoplasm (SM-AHN), or mast cell leukemia (MCL).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		for acute myeloid leukemia					
SANDOSTATIN LAR DEPOT			Acromegaly: The member must have a diagnosis of Acromegaly. Mmust have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have above grade 3 diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine.. Treatment of		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.				
SAPHRIS		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia/Bipolar I Disorder, manic or mixed episodes. The member must be utilizing Saphris (asenapine) for treatment of schizophrenia or bipolar I disorder. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SAPROPTERIN			BH4 (Sapropterin) responsive PKU. Diagnosis of PKU that is responsive to BH4. Response is defined as a 20% or greater reduction of blood Phe level from baseline during treatment for one to two months.		Licensed Practitioner	First approval: three months. if response is positive extended for plan year duration.	
SARCLISA		The member has experienced disease progression while on or following an anti-CD38 inhibitor (e.g. daratumumab, isatuximab-irfc).	Multiple myeloma (third line). The member has a diagnosis of multiple myeloma AND The member will be using Sarclisa (isatuximab-irfc) in combination with Pomalyst (pomalidomide) and dexamethasone AND The member has received at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (e.g. bortezomib, carfilzomib).		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SCENESSE			Erythropoietic Protoporphyria. Initial Review: Member has a diagnosis of erythropoietic protoporphyria confirmed by elevated free erythrocyte protoporphyrin and/or identification of pathogenic variants in ferrochelatase (FECH) on molecular genetic testing AND Member has a history of phototoxic cutaneous reactions (e.g. pain, stinging, redness, swelling). Continuation of Therapy: The member has had a positive clinical response (e.g. reduction in number of phototoxic reactions, increase in duration of pain-free sun exposure).	Member is 18 years of age or older	Licensed Practitioner	Plan Year Duration	
SECUADO		Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.	Schizophrenia: The member has diagnosis of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SENSIPAR			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
SEVENFACT					Licensed Practitioner	Plan Year Duration	
SIGNIFOR			Cushing's disease: Diagnosis of Cushing's disease AND Pituitary surgery is not an option or has not been curative AND No severe hepatic impairment (Child-Pugh C).		Licensed Practitioner	6 months for initial approval.	Reauthorization criteria for additional 180 days are as follows: No severe hepatic impairment (Child-Pugh C AND Urinary Free Cortisol (UFC) level has decreased from baseline at start of Signifor (pasireotide) treatment.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SILDENAFIL (PULM.HYPERTENSION)		Concurrent use of nitrates (e.g., nitroglycerin). Concurrent use of HIV protease inhibitors (e.g., ritonavir). Concurrent use with guanylate cyclase stimulators (e.g., riociguat). Concurrent use of another PDE5 inhibitor (e.g., tadalafil)	Pulmonary Arterial Hypertension (PAH).The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had prior therapy, contraindication, or intolerance to a phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SILDENAFIL (PULM.HYPERTENSION)		Concurrent use of nitrates (e.g., nitroglycerin). Concurrent use of HIV protease inhibitors (e.g., ritonavir). Concurrent use with guanylate cyclase stimulators (e.g., riociguat). Concurrent use of another PDE5 inhibitor (e.g., tadalafil)	Pulmonary Arterial Hypertension(PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SINUVA			Nasal Polyps: The member must have a diagnosis of nasal polyps AND The member must have had a history of ethmoid sinus surgery AND the member has had previous treatment, contraindication, or intolerance with two of the following intranasal products: fluticasone propionate, mometasone, Qnasl, Nasonex, Beconase AQ AND Sinuva nasal implant will be used in conjunction with mometasone furoate nasal spray once daily.	The member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration	
SIRTURO			Multidrug-resistant tuberculosis (MDR-TB). The member must have a diagnosis of pulmonary multidrug-resistant tuberculosis (MDR-TB) confirmed by drug susceptibility testing (DST. Susceptibility to bedaquiline has been confirmed by DST. Bedaquiline will be used as part of a multidrug regimen.		Licensed Practitioner	24 weeks duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SKYRIZI		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade).	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. acitretin, methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments.	The member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration	
SMART CARESENS N			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMART SENSE MONITORING SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SMART SENSE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMARTEST EJECT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SMARTEST PERSONA GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMARTEST PERSONA STARTER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SMARTEST PRONTO GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMARTEST PRONTO STARTER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SMARTEST PROTEGE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMARTEST SMART CODE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SMARTEST TALKING METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SMARTEST TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SODIUM HYALURONATE (VISCOSUP)			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOFOSBUVIR-VELPATASVIR			Chronic Hepatitis C Virus Genotypes: The member must have a diagnosis of chronic hepatitis C (HCV). The member must have HCV genotype documented prior to therapy. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.	6 years of age or older OR weigh at least 37 pounds (17 kilograms).	Licensed Practitioner.	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	
SOLIRIS		Member has unresolved serious Neisseria meningitides infection. Members with Shiga toxin E.Coli related hemolytic uremic syndrome (STEC-HUS).	Paroxysmal Nocturnal Hemoglobinuria (PNH): Documentation in the medical record supporting the diagnosis of PNH defined as granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal		Licensed Practitioner	PNH, aHUS, NMOSD: Plan Year Duration. gMG: Initial: 7 months, Reauth: 1 year duration.	Generalized Myasthenia Gravis (gMG): The member must have a diagnosis of anti-acetylcholine receptor (AchR) antibody positive generalized Myasthenia Gravis (gMG) AND have one of the following: History of abnormal neuromuscular transmission test demonstrated by single-fiber

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			to 7 g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL AND Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). PNH Reauthorization: Documentation in the medical record demonstrating a positive clinical response from baseline (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions). Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) AND Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency). aHUS Reauthorization: Documentation in the medical record demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased				electromyography (SFEMG) or repetitive nerve stimulation OR History of positive anticholinesterase test (e.g. edrophonium chloride test) OR The member has demonstrated improvement in MG signs on oral cholinesterase inhibitors. The member must have Myasthenia Gravis Foundation of America (MFGA) clinical classification of Class II, III, or IV upon initiation of therapy. The member must have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of at least 6 or higher upon initiation of therapy. The member must have failed treatment (e.g. experienced disease or symptom progression) with at least two immunosuppressive agents

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			platelet count, reduction of hemolysis).				(e.g. cyclosporine, azathioprine) OR at least one immunosuppressive agent and required chronic plasma exchange or Intravenous Immune Globulin (IVIg). MG Reauthorization: The member must have at least a 3 point reduction in MG-ADL total score from baseline OR the member must have at least a 5 point reduction in Quantitative Myasthenia Gravis test (QMG) from baseline. Neuromyelitis Optica Spectrum Disorder (NMOSD): the member must have at least one of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: optic neuritis, acute myelitis, area postrema syndrome: episode of

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							otherwise unexplained hiccups or nausea and vomiting, acute brainstem syndrome, symptomatic narcolepsey or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions. The member must be anti-aquaporin-4 (AQP4) antibody positive. NMOSD reauthorization: documentation in the medical record demonstrating a positive clinical response from baseline (e.g. reduced rates of hospitalization, corticosteroid administrations to treat acute relapses, plasma exchange treatments).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOLUS V2 AUDIBLE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SOLUS V2 TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOMATULINE DEPOT			Diagnosis of acromegaly, IGF-1 levels, GH levels. The patient has a diagnosis of acromegaly. The patient has had an inadequate response to or cannot be treated with surgical resection OR The patient has had an inadequate response to or cannot be treated with radiation therapy. Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Carcinoid Syndrome: The member has a diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.		Licensed Practitioner	Plan year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOMAVERT			Pegvisomant may be considered medically necessary when the following criteria are met for their respective indication(s): Acromegaly. The member must have a diagnosis of acromegaly. The member had inadequate response to surgery or radiation therapy, AND one dopamine agonists (i.e. bromocriptine)or one somatostatin analogues (i.e. octreotide, lanreotide).		Licensed Practitioner	Plan year duration	
SPRYCEL		Members on concomitant tyrosine kinase inhibitors, Members that have experienced disease progression while on dasatinib.	Chronic Myelogenous Leukemia (CML): The member has a diagnosis of Ph+ chronic myeloid leukemia (CML) and one of the following applies: Primary treatment for newly diagnosed OR Treatment of chronic, accelerated, myeloid, or lymphoid blast phase CML with resistance or intolerance to prior therapy OR Documented mutation of Y253H, E255K/V, or F359V/C/I. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive)and Sprycel is being used for induction or consolidation		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatment in combination with chemotherapy or corticosteriods OR treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy. Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib) or Sutent (sunitinib)or Stivarga. [Pediatric] Chronic Myelogenous Leukemia (CML). The member has a diagnosis of chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) AND the member is in chronic phase. [Pediatric] Acute lymphoblastic leukemia (ALL). The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member has Philadelphia chromosome positive (Ph+) disease AND the member has newly-diagnosed disease AND The member will be using Sprycel in combination with chemotherapy.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
STALEVO 100			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STALEVO 125			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STALEVO 150			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STALEVO 200			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STALEVO 50			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STALEVO 75			Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
STELARA		Combination therapy with other biologics (e.g. Cosentyx, Enbrel,	Moderate to severe chronic plaque psoriasis - Adults (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque	Moderate to severe chronic plaque psoriasis - Pediatric: The member must be	Licensed Practitioner	Plan Year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Humira, Kevzara, Remicade).	psoriasis AND The member has had prior therapy, contraindication or intolerance with two of the following: Humira, Enbrel, Consentyx or Skyrizi*. (*-Previous therapy requirements with SKyrizi do not apply to Walmart Value Rx PDP requests – Skyrzi is non-formulary on Walmart Value Rx PDP). Moderate to severe chronic plaque psoriasis - Pediatric (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance with Enbrel. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: Humira, Enbrel or Consentyx. Moderately to severely active Crohn's disease and moderately to severely active ulcerative colitis (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease or moderately to severely	6 to 18 years of age. For all other indications: Must be 18 years of age or older.			

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Humira.				
STIVARGA		The member has experienced disease progression while on Stivarga (regorafenib).Members on concomitant tyrosine kinase inhibitors.	Metastatic Colorectal Cancer.The member has a diagnosis of metastatic colorectal cancer AND The member is using Stivarga (regorafenib) as monotherapy AND The member has documented intolerance, contraindication or has failed previous treatment with ALL of the following therapies: fluoropyrimidine (regimens include 5-FU/capecitabine),oxaliplatin-based chemotherapy,irinotecan-based chemotherapy, and anti-VEGF therapy (e.g., bevacizumab, ziv-aflibercept) AND If the member is RAS wild-type and has documented intolerance, contraindication or has failed previous treatment with anti-EGFR therapy (e.g., cetuximab, panitumumab).Gastrointestinal Stromal Tumor.The member has a diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor AND The member has experienced		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			disease progression, intolerance, or contraindication with imatinib mesylate and sunitinib malate. Hepatobiliary Cancers: The member has a diagnosis of hepatocellular carcinoma AND Stivarga (regorafenib) is being given as monotherapy AND The member has experienced progression on or after sorafenib (Nexavar).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
STRENSIQ			Hypophosphatasia (HPP):The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile onset hypophosphatasia. Hypophosphatasia (HPP):The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile-onset hypophosphatasia defined by:Low total serum alkaline phosphatase (ALP) activity determined by the gender- and age-specific reference range, AND Elevated urine concentration of phosphoethanolamine (PEA) determined by age-specific reference range, OR Elevated serum pyridoxal 5'-phosphate (PLP) level (normal range 5 – 50 mcg/L), OR Documented gene mutation of tissue-nonspecific alkaline phosphatase (TNSALP).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SUBLOCADE			Treatment of moderate to severe Opioid Use Disorder- Initial Therapy: Member is using Sublocade (buprenorphine extended-release) for the treatment of moderate to severe opioid use disorder (OUD) AND The member must have initiated treatment with a transmucosal buprenorphine containing product followed by a dose adjustment for a minimum of 7 days AND Monthly drug screenings must be performed and accompany the prior authorization request AND Evidence of active substance abuse counseling must accompany the prior authorization request. Continuing Therapy: Monthly drug screenings must be performed and accompany the prior authorization request AND Evidence of active substance abuse counseling must accompany the prior authorization request.		Licensed Practitioner	Plan Year Duration	
SUPARTZ FX			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SUPPRELIN LA		Members who are pregnant or lactating. Concomitant use with other LHRH agents.	Supprelin LA (histrelin acetate) implant will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Central Precocious Puberty. Pediatric member has a diagnosis of either neurogenic or idiopathic central precocious puberty.	2 years or older	Licensed Practitioner	Plan Year	
SURE-TEST EASYPLUS MINI			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SURE-TEST EASYPLUS MINI METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
SUTENT		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Sutent. Member not to exceed a total treatment of 54 weeks (applicable	Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST)AND the member has disease progression on or intolerance to imatinib mesylate. Advanced renal cell carcinoma(RCC).Diagnosis of advanced renal cell carcinoma (stage IV). Renal Cell Carcinoma (RCC) Adjuvant Therapy. The member has high risk (i.e. tumor stage T3 or higher, regional lymph node metastases, or both) of recurrent RCC following nephrectomy AND Sutent (sunitinib) will be used as a single agent as		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		to adjuvant therapy for renal cell carcinoma).	adjuvant treatment. Pancreatic neuroendocrine tumors (PNET). Diagnosis of Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) AND The member has unresectable locally advanced or metastatic disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular carcinoma, Hurthle cell carcinoma, papillary or medullary carcinoma (types of thyroid carcinoma) and clinical trials are not available or appropriate. Follicular, papillary, or Hurthle cell carcinoma are not responsive to radio-iodine treatment OR The member has a diagnosis of advanced medullary carcinoma-disseminated symptomatic disease (thyroid carcinoma) and has disease progression or has an intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Advanced/Metastatic Angiosarcoma. Diagnosis of advanced/metastatic angiosarcoma AND Sutent (sunitinib) is being utilized as a single agent/monotherapy (without				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			concomitant chemotherapy or biologics).Thymomas/thymic carcinoma: The member will be using as monotherapy in the second line.				
SYLATRON		Members with hepatic decompensation (Child-Pugh score greater than 6 [class B and C]). Members that have experienced disease progression while on Sylatron (peginterferon alfa-2b)	Sylatron (peginterferon alfa-2b) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Melanoma. The member has a diagnosis of cutaneous melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy. Sylatron (peginterferon alfa-2b) is being used as adjuvant treatment. Myeloproliferative Neoplasms. The member has a diagnosis of symptomatic low risk myelofibrosis.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SYLVANT			Multicentric Castleman's Disease:The member has a diagnosis of member has a diagnosis of multicentric Castleman's disease.The member is human immunodeficiency (HIV) and human herpes virus (HHV-8) negative.The member has an absolute neutrophil count greater than or equal to 1.0 x 109/L, a platelet count of greater than or equal to 75 x 109, and hemoglobin level less than 17 g/dL.Reauthorization Criteria:The approval duration may be continued for 6 additional months if benefit is shown via no evidence of disease progression/treatment failure and the following laboratory parameters are met: The member has an absolute neutrophil count greater than or equal 1.0 x 109/L, a platelet count of greater than or equal 50 x 109, and hemoglobin level less than 17 g/dL.		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SYMPAZAN			Lennox-Gastaut Syndrome: The member has a diagnosis of Lennox-Gastaut Syndrome AND the member will be taking at least one concomitant anti-epileptic medication therapy AND the member has had prior therapy AND has a documented contraindication (e.g. dysphagia) to BOTH a generic clobazam tablet AND oral suspension formulation.	The member is 2 years of age or older.	Licensed Practitioner	Plan year duration	
SYNRIBO		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Synribo (omacetaxine mepesuccinate).	Chronic Myelogenous Leukemia.The member has a diagnosis of Philadelphia chromosome positive chronic or accelerated phase chronic myeloid leukemia AND one of the following applies: The member has had prior therapy, intolerance, or resistance to at least two of the following tyrosine kinase inhibitors: imatinib, Sprycel, Tasigna, or Bosulif OR The member has a documented T315I mutation.		Licensed Practitioner	6 month duration	
SYNVISC			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SYNVISC-ONE			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
TABRECTA		Member experiences disease progression on Tabrecta (capmatinib).	Non-Small Lung Cell Cancer (NSCLC): The member has a diagnosis of metastatic NSCLC AND the disease is documented MET exon 14 skipping positive AND Tabrecta (capmatinib) is being used as monotherapy.		Licensed Practitioner	6 Months Duration	
TADALAFIL (PULM. HYPERTENSION)		Concurrent use of nitrates (e.g., nitroglycerin) OR Concurrent use of another PDE5 inhibitor, sildenafil (Revatio)	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan year duration	
TAFINLAR		Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo	Melanoma-Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenib) as monotherapy OR		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(nivolumab), Keytruda (pembrolizumab) Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Tafinlar (dabrafenib). Members that have experienced disease progression while on Zelboraf (vemurafenib). Members that have experienced disease progression while	in combination with Mekinist (trametinib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer (NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenic) in combination with Mekinist (trametinib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)]. Adjuvant melanoma only: member is taking Tafinlar (dabrafenib) total treatment for more than one year.					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAGRISSO		Members on concomitant tyrosine kinase inhibitors. Members who have disease progression on Tagrisso (osimertinib).	Non small cell lung cancer NSCLC:The member has a diagnosis of metastatic non small cell lung cancer (NSCLC) and the following criteria applies: The member has documented sensitizing EGFR mutations (exon 19 deletions or exon 21 L858R) AND Tagrisso (osimertinib) is being used as single agent for first line therapy OR The member has a documented epidermal growth factor receptor (EGFR) T790M mutation AND Tagrisso (osimertinib) is used as monotherapy after progression of EGFR inhibitors (e.g., erlotinib, gefitinib).		Licensed Practitioner	Six month duration	
TALZENNA		Members have experienced disease progression while on or following PARP inhibitor therapy (eg, olaparib).	Breast Cancer. Member has a diagnosis of locally advanced or metastatic, HER-2 negative breast cancer AND Member has documented deleterious germline or suspected germline BRCAmutated disease AND if member has hormone receptor positive disease then is endocrine refractory AND Talzenna (talazoparib) will be used as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TARGRETIN		Members that are pregnant. Members on concomitant retinoid therapy.	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.		Licensed Practitioner	Plan Year Duration	
TASIGNA		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while	Chronic Myelogenous Leukemia (CML). The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR For members with a diagnosis of chronic phase CML that has not been previously	Pediatric CML-member is greater than or equal to 1 year of age.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on Tasigna (nilotinib).	treated, one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib and Sprycel (dasatinib) OR Documented mutation of F317L/V/I/C, T315A, or V299L OR For members with a diagnosis of chronic phase CML that has received previous treatment, one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Sprycel (dasatinib) OR Documented mutation of F317L/V/I/C, T315A, or V299L. Advanced Gastrointestinal Stromal Tumor				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(GIST). Diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib), Sutent (sunitinib),or Stivarga.Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia. Pediatric CML: Diagnosis of chronic phase Ph+ chronic myeloid leukemia (CML).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAZAROTENE			The treatment of acne vulgaris: The member must have a documented diagnosis of acne vulgaris AND The member must have had previous treatment, or intolerance to generic topical tretinoin (non-micro). Generic topical tretinoin cream/gel has additional prerequisite requirements. The treatment of stable plaque psoriasis: The member must have a documented diagnosis of stable plaque psoriasis AND The member must have had previous treatment , intolerance, or contraindication to topical clobetasol propionate cream/gel/lotion/ointment/solution or betamethasone dipropionate.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAZORAC			The treatment of acne vulgaris: The member must have a documented diagnosis of acne vulgaris AND The member must have had previous treatment, or intolerance to generic topical tretinoin (non-micro). Generic topical tretinoin cream/gel has additional prerequisite requirements. The treatment of stable plaque psoriasis: The member must have a documented diagnosis of stable plaque psoriasis AND The member must have had previous treatment , intolerance, or contraindication to topical clobetasol propionate cream/gel/lotion/ointment/solution or betamethasone dipropionate.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAZVERIK		The member experiences disease progression on Tazverik	The member has a diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection AND Tazverik will be given as monotherapy. Follicular lymphoma: The member has a diagnosis of relapsed/refractory follicular lymphoma AND one of the following applies: The member has a documented EZH2 mutation by an FDA approved test and the member has received at least two prior therapies and the member will be using Tazverik (tazemetostat) as monotherapy OR The member has no satisfactory alternative treatment options and The member will be using Tazverik (tazemetostat) as monotherapy.	The member is 16 years of age or older	Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TD GOLD BLOOD GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
TD GOLD TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TD GOLD VOICE GLUCOSE MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TECARTUS		The member has received prior CD-19 targeted CAR-T cell therapy (e.g. tisagenlecleucel). The member has active hepatitis B (HBs AG-positive) or hepatitis C infection. The member has HIV/AIDs. The member has a diagnosis of primary central nervous system lymphoma. The member has received prior allogeneic transplant.	Mantle cell lymphoma: The member has a diagnosis of mantle cell lymphoma AND The member has relapsed or refractory disease, defined as disease progression after their last regimen or refractory disease to their most recent therapy AND The member has had prior therapy with chemoimmunotherapy (e.g. anthracycline-based regimen and anti-CD-20 monoclonal antibody) and a Bruton tyrosine kinase inhibitor (e.g. acalabrutinib or ibrutinib) AND The member will be using Tecartus (brexucabtagene autoleucel) in conjunction with lymphodepleting chemotherapy (fludarabine 30 g/m2 daily for 3 days and cyclophosphamide 500 mg/m2 daily for 3 days) AND The member will be using Tecartus (brexucabtagene autoleucel) at a treatment center that is certified to administer Tecartus (brexucabtagene autoleucel).	The member is greater than or equal to 18 years of age.	Licensed Practitioner	60 days duration	
TECENTRIQ		Disease progression while	Urothelial cancer: The member has a diagnosis of locally advanced or		Licensed Practitioner	6 months duration	Small Cell Lung Cancer: The member has a diagnosis of

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]).	metastatic urothelial cancer AND The member will be using Tecentriq (atezolizumab) as a single agent AND One of the following apply: Tecentriq is being used as initial therapy in members who are ineligible to receive cisplatin containing chemotherapy and disease expressing PD-L1 (i.e., PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area) OR Tecentriq is being used as initial therapy in members who are ineligible to receive platinum containing chemotherapy regardless of PD-L1 status OR Tecentriq is being used as subsequent therapy after disease progression within 12 months of neoadjuvant or adjuvant treatment. Non-Small Cell Lung Cancer: metastatic NSCLC with non-squamous cell histology AND member has disease with no EGFR or ALK genomic tumor aberrations AND Tecentriq will be given as a component of one of the two combo regimens: in combination with carboplatin and				extensive-stage small cell lung cancer AND Tecentriq will be given in combination with etoposide and carboplatin as first line therapy followed by maintenance therapy with Tecentriq. Triple-Negative Breast Cancer: The member has a diagnosis of unresectable locally advanced or metastatic triple negative breast cancer AND The disease is PD-L1 positive (e.g., PD-L1 expression covering greater than or equal to 1% of the tumor area) per FDA approved test AND Tecentriq is given in combination with Abraxane. Heptatocellular Carcinoma: The member has a diagnosis of unresectable or metastatic hepatocellular carcinoma AND Tecentriq (atezolizumab) will be used as

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			paclitaxel and Avastin as first line therapy followed by maintenance therapy with combination Tecentriq and Avastin OR in combo with Abraxane (nabpaclitaxel) and carboplatin as first line therapy. OR The member must have a diagnosis of metastatic squamous or non-squamous nonsmall cell lung cancer AND has experienced disease progression on or after chemotherapy and EGFR inihibitor (e.g.,Tarceva [erlotinib], Iressa [gefitinib], Gilotrif [afatinib]), if EGFR mutation positive or ALK inhibitor (e.g., Xalkori (crizotinib)), if ALK positive AND the member will be using Tecentriq as monotherapy. OR metastatic NSCLC AND Disease has high PD-L1 expression [PD-L1 stained greater than or equal to 50% of tumor cells OR PD-L1 stained tumor-infiltrating immune cells covering greater than or equal to 10% of the tumor area] AND PD-L1 tumor expression is determined by an FDA-approved test AND disease has no EGFR or ALK genomic tumor aberrations and will be given as 1st				first line therapy in combination with bevacizumab. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND the member will use Tecentriq in combination with Cotellic (cobimetinib) and Zelboraf (vemurafenib).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			line therapy AND as monotherapy.				
TECFIDERA		Combination use with other disease modifying drugs for MS including Avonex, Betaseron, Extavia, Copaxone, Rebif, Tysabri, Aubagio, or Gilenya.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner.	Plan Year Duration.	
TELCARE BGM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TELCARE BLOOD GLUCOSE KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
TELCARE TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
TEMODAR		Temozolomide is contraindicated in	Glioblastoma Multiforme/ Anaplastic Astrocytoma: The member is an adult		Licensed Practitioner	6 months duration	Neuroendocrine Tumors of the Lung or Thymus: The

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		member with a history of hypersensitivity to dacarbazine.	with glioblastoma multiforme (GBM)or anaplastic astrocytoma and Temodar (temozolomide) is being used as the following: Newly diagnosed GBM or anaplastic astrocytoma as a single agent or in combination with radiotherapy OR Maintenance therapy for GBM or anaplastic astrocytoma or treatment of recurrent disease as a single agent or in combination with bevacizumab product for GBM or anaplastic astrocytoma. Low Grade Gliomas: The member is an adult with low grade infiltrative supratentorial astrocytoma or oligodendroglioma AND The member has disease progression on a regimen containing carmustine, lomustine, or procarbazine AND The member must use Temodar (temozolomide) as a single agent for recurrent or progressive disease OR The member must use Temodar (temozolomide) as a single agent as adjuvant thearpy. Ewing's Sarcoma: The member has Ewing’s sarcoma and Temodar (temozolomide) is being used in				member has locoregional or metastatic neuroendocrine carcinoma and Temodar (temozolomide)is being used as a single agent. Mycosis fungoides (MF)/Sezary syndrome(SS): The member has a diagnosis of MF/SS. Primary Central Nervous System (CNS) Lymphoma: The member has a diagnosis or primary CNS lymphoma and will be using Temodar (temozolomide) in combination with high-dose methotrexate and rituximab product OR The member has progressive or recurrent primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent or in combination with rituximab product. Soft tissue sarcoma: The member has diagnosis of soft tissue

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			combination with irinotecan for one of the following: Relapse therapy. Progressive disease following primary treatment. Melanoma: The member has diagnosis of unresectable or recurrent melanoma and Temodar (temozolomide) is being used as a single agent for subsequent therapy. Neuroendocrine Tumors of the Pancreas: The member has diagnosis of unresectable locoregional and/or distant metastatic neuroendocrine tumors of the pancreas (islet cell tumors) and Temodar is being as single agent or in combo with Xeloda for the management of symptomatic disease, clinically significant tumor burden or clinically significant progression.				sarcoma. Anaplastic Gliomas. The member has diagnosis of Anaplastic Gliomas and Temodar (temozolomide) will be used as monotherapy and one of the following applies: adjuvant treatment or recurrent disease OR Temodar (temozolomide) will be given in combination with bevacizumab product for treatment of recurrent disease.
TEMOZOLOMIDE		Temozolomide is contraindicated in member with a history of hypersensitivity to dacarbazine.	Glioblastoma Multiforme/ Anaplastic Astrocytoma: The member is an adult with glioblastoma multiforme (GBM)or anaplastic astrocytoma and Temodar (temozolomide) is being used as the following: Newly diagnosed GBM or anaplastic astrocytoma as a single agent		Licensed Practitioner	6 months duration	Neuroendocrine Tumors of the Lung or Thymus: The member has locoregional or metastatic neuroendocrine carcinoma and Temodar (temozolomide)is being used as a single agent. Mycosis

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			or in combination with radiotherapy OR Maintenance therapy for GBM or anaplastic astrocytoma or treatment of recurrent disease as a single agent or in combination with bevacizumab product for GBM or anaplastic astrocytoma. Low Grade Gliomas: The member is an adult with low grade infiltrative supratentorial astrocytoma or oligodendroglioma AND The member has disease progression on a regimen containing carmustine, lomustine, or procarbazine AND The member must use Temodar (temozolomide) as a single agent for recurrent or progressive disease OR The member must use Temodar (temozolomide) as a single agent as adjuvant thearpy. Ewing's Sarcoma: The member has Ewing's sarcoma and Temodar (temozolomide) is being used in combination with irinotecan for one of the following: Relapse therapy. Progressive disease following primary treatment. Melanoma: The member has diagnosis of unresectable or recurrent				fungoides (MF)/Sezary syndrome(SS): The member has a diagnosis of MF/SS. Primary Central Nervous System (CNS) Lymphoma: The member has a diagnosis or primary CNS lymphoma and will be using Temodar (temozolomide) in combination with high-dose methotrexate and rituximab product OR The member has progressive or recurrent primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent or in combination with rituximab product. Soft tissue sarcoma: The member has diagnosis of soft tissue sarcoma. Anaplastic Gliomas. The member has diagnosis of Anaplastic Gliomas and Temodar (temozolomide) will be used as monotherapy and

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			melanoma and Temodar (temozolomide) is being used as a single agent for subsequent therapy. Neuroendocrine Tumors of the Pancreas: The member has diagnosis of unresectable locoregional and/or distant metastatic neuroendocrine tumors of the pancreas (islet cell tumors) and Temodar is being as single agent or in combo with Xeloda for the management of symptomatic disease, clinically significant tumor burden or clinically significant progression.				one of the following applies: adjuvant treatment or recurrent disease OR Temodar (temozolomide) will be given in combination with bevacizumab product for treatment of recurrent disease.
TEMSIROLIMUS		Patients that have experienced disease progression while on temsirolimus.	The member has a diagnosis of advanced/metastatic renal cell carcinoma (stage IV). Endometrial cancer: The member has a diagnosis of endometrial cancer AND the member has been surgically staged and found to be stage IIIA-IVB and Torisel will be used as adjuvant therapy OR Torisel (temsirolimus) will be used as primary treatment. OR The member has a diagnosis of recurrent or metastatic endometrial cancer.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TEST N'GO BLOOD GLUCOSE SYSTEM			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
TEST N'GO TEST			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TESTOPEL			Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% formulation AND one of the following: testosterone cypionate or testosterone enanthate.		Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TESTOSTERONE			Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TETRABENAZINE		Concomitant use of an MAOI or reserpine.	Tetrabenazine may be considered medically necessary when the following criteria is met: Diagnosis of chorea associated with Huntington's disease.		Licensed Practitioner.	Plan Year Duration.	
THALOMID		Members on concomitant Revlimid (lenalidomide) or Pomalyst (pomalidomide). Members that have experienced disease progression while on thalidomide.	Thalomid (thalidomide) will require prior authorization and may be considered medically necessary when the following criteria are met for the following indication(s):Erythema Nodosum Leprosum (ENL).The member is currently having acute cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) OR Thalomid (thalidomide) is prescribed for maintenance therapy for prevention and suppression of the cutaneous manifestations of (ENL) recurrence.Multiple Myeloma.The member has a diagnosis of Multiple Myeloma. Waldenstöm's Macroglobulinemia.The member has a diagnosis of Waldenstöm's macroglobulinemia or lymphoplasmacytic lymphoma AND Thalomid (thalidomide) is		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Thalomid (thalidomide) is being used as monotherapy or in combination with Rituxan (rituximab).				
THROMBATE III					Licensed Practitioner	Plan Year Duration	
TIBSOVO		Member has experienced disease progression while on or following Tibsovo (ivosedinib).	Acute Myeloid Leukemia-Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND one of the following applies: The member will be using Tibsovo (ivosedinib) as monotherapy OR the member will be using Tibsovo as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia – Newly diagnosed: The member has a diagnosis of acute myeloid		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			leukemia (AML) AND the member has newly diagnosed disease AND one of the following applies: the member is 60 years of age or older and is not a candidate for intensive induction therapy due to comorbidities OR the member is 60 years of age or older and the member declines intensive induction therapy OR the member is 75 years of age or older. The member has a documented IDH1 mutation as detected by an FDA-approved test AND the member will be using Tibsovo as monotherapy.				
TOBI PODHALER		Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 80% predicted. Patients colonized with Burkholderia cepacia.	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa.	Must be 6 years of age or older.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TOBRAMYCIN		Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 80% predicted. Patients colonized with Burkholderia cepacia.	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa.	Must be 6 years of age or older.	Licensed Practitioner	Plan Year Duration	
TRACLEER		The member is concomitantly taking cyclosporine-A or glyburide.The member is concomitantly taking endothelin receptor antagonist (e.g., Letairis, Opsumit).	Pulmonary Arterial Hypertension (PAH)-Adult: The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had previous treatment or intolerance with one of the following: sildenafil tablet, Revatio oral suspension, or Tracleer tablet. Pulmonary Arterial Hypertension (PAH)- Pediatric: The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRACLEER		The member is concomitantly taking cyclosporine-A or glyburide.The member is concomitantly taking endothelin receptor antagonist (e.g., Letairis, Opsumit).	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. For Brand Request: Member must have had previous treatment, intolerance, or contraindication with a generic ERA (e.g., ambrisentan, bosentan).		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRAZIMERA			For Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), or Ontruzant (trastuzumabdttb) requests: member must have an intolerance or contraindication Herceptin (trastuzumab) or Trazimera (trastuzumab–qyyp) or Kanjinti (trastuzumab-anns) and meets below criteria. Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease. Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.		Licensed Practitioner	6 months duration	
TREANDA		Members who experience disease progression on bendamustine containing regimens.	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL without del(17p)/TP53 mutation and with or without del(11q) AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a		Licensed Practitioner	6 months duration.	Waldenström's Macroglobulinemia:The member has Waldenström's macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma or nongastric MALT lymphoma and is using Bendamustine. The member has a diagnosis of mantle cell lymphoma and bendamustine is being used as one of the following: Less aggressive induction therapy OR Second-line therapy for relapsed, refractory or progressive disease. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with rituximab in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line				following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy .The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.				
TRELSTAR		Concomitant use with other LHRH agonists.	Prostate Cancer.The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.		Licensed Practitioner	Plan Year Duration	
TRETINOIN			Approval will be given to all members using this agent for medically necessary, FDA approved or compendia supported, non-cosmetic indications.		Licensed Practitioner.	Plan Year Duration.	
TRETTEN					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRIHEXYPHENIDYL			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	
TRIKAFTA			Cystic Fibrosis: The member has a diagnosis of Cystic Fibrosis AND Member does not have severe liver impairment (Child-Pugh Class C) AND Submission of Lab testing to confirm at least one F508del mutation.	Member is 12 years of age or older.	Licensed Practitioner	Plan Year Duration	
TRILURON			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
TRIMIPRAMINE			The physician has documented the indication for the continued use of the HRM (high risk med) and the benefit outweighs the potential risk OR the member is currently taking a protected medication class (i.e., antidepressants, antipsychotics, anticonvulsants).	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.	Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRISENOX			Acute Promyelocytic Leukemia (APL). The member has a diagnosis of acute promyelocytic leukemia AND the member will be using Trisenox (arsenic trioxide) for induction therapy, consolidation therapy, or relapsed disease.		Licensed Practitioner	6 months duration	
TRIVISC			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				
TRODELVY		Members experienced disease progression on Trodelvy (sacituzumab govitecan-hziy).	Breast Cancer. The member has metastatic triple negative breast cancer AND The member has received at least two prior therapies for metastatic disease AND Trodelvy (sacituzumab govitecan-hziy) is given as single agent as subsequent therapy.		Licensed Practitioner	Six month duration	
TRUXIMA		High dose CLL therapies (doses greater than 500mg/m^2). The member will be using rituximab as maintenance	For requests for Truxima: member must have intolerance or contraindication with Rituxan (rituximab) or Ruxience (rituximab-pvvr). Truxima and Ruxience requests are only for NHL, CLL, RA, granulomatosis with polyangitis (GPA) (Wegener’s Granulomatosis), and	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.	Licensed Practitioner	Plan Year Duration	The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder.The member has a diagnosis of Post-transplant

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).	microscopic polyangitis (MPA). Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with: Remicade OR Inflectra AND Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab therapy, unless contraindicated or intolerant to methotrexate.				Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER:Platelet count less than 25,000/µL OR Active bleeding due to inadequate platelet function.The member must have had an

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months.Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
TUKYSA		Member experiences disease progression on Tukysa (tucatinib)	Breast Cancer. The member has metastatic or advanced unresectable HER 2 positive breast cancer (inclusive of brain metastases) and all of the following apply: Member has received one or more prior anti-HER2 based regimen in the metastatic setting AND Tukysa is given in combination with trastuzumab product and capecitabine as subsequent therapy.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TURALIO			Symptomatic Tenosynovial Giant Cell Tumor: The member has symptomatic tenosynovial giant cell tumor (TGCT) and the disease is associated with severe morbidity or functional limitations and the disease is not amenable to improvement with surgery and Turalio (pexidartinib) will be used as monotherapy.		Licensed Practitioner	6 months duration	
TYKERB		Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progressionwhile on Tykerb (lapatinib).	Breast Cancer. The member has a diagnosis of HER2(human epidermal growth factor receptor2) positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline (e.g. doxorubicin) and a taxane (e.g.paclitaxel)OR The member has a diagnosis of HER2 positive metastatic breast cancer AND Used as first line treatment in combination with an aromatase inhibitor (Femara/letrozole, Arimidex/anastrozole or Aromasin/exemestane) for hormone receptor positive disease.		Licensed Practitioner	6 month duration	
UDENYCA		Concomitant use	Febrile Neutropenia Prophylaxis. The		Licensed	4 months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(within seven days of Udenyca (pegfilgrastim-cbqv) dose) with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrastim, or sargramostim. Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once	member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than		Practitioner	duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		per chemotherapy cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	2.0 mg/dL) OR Renal dysfunction (creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.				
ULTIMA MONITOR			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ULTIMA TEST STRIPS			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ULTOMIRIS		Patients with unresolved Neisseria Meningitidis infection	Paroxysmal Nocturnal Hemoglobinuria (PNH). Initial Therapy: Documentation in the medical record supporting the diagnosis of PNH defined as: granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal to 7g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL,		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Reauthorization: Documentation in the medical record demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis).Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) and Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency). aHUS reauthorization: Physician attestation of a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis, reduction in LDH).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ULTRATRAK			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
ULTRATRAK GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ULTRATRAK ULTIMATE			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
UNISTRIP1 TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
UNITUXIN		Members receiving Unituxin (dinutuximab)as monotherapy.Members that have experienced disease progression while on Unituxin (dinutuximab).	High-risk neuroblastoma:The member has a diagnosis of high-risk neuroblastoma ANDUnituxin (dinutuximab) will be used in combination with isotretinoin AND Unituxin (dinutuximab) will be used in alternating cycles of Leukine (sargramostim) and Proleukin (aldesleukin) AND The member has achieved at least a partial response to the following: Induction combination chemotherapy AND Maximum feasible surgical resection The member has had the previous procedure/therapy: Myeloablative consolidation chemotherapy followed by autologous stem cell transplantation AND Radiation therapy to residual soft tissue disease.	Memebr must be 18 years of age or younger.	Licensed Practitioner	Six month duration	
UPLIZNA					Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VALCHLOR		Members that have experienced disease progression while on Valchlor (mechlorethamine).	Cutaneous T-Cell Lymphoma: The member has a diagnosis of fungoides-type cutaneous T-cell lymphoma AND The member has had prior therapy with skin-directed therapy or using as primary treatment.		Licensed Practitioner	Plan Year Duration	
VALRUBICIN		The member must not have an active urinary tract infection (UTI).	This agent may be considered medically necessary when the following criteria are met:Bladder Cancer.The member has recurrent or persistent carcinoma in situ of the urinary bladder(Cis).The member has experienced disease progression, intolerance or has a contraindication to BCG therapy.The member is not a candidate for immediate cystectomy.		Licensed Practitioner.	six months	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VALSTAR		The member must not have an active urinary tract infection (UTI).	This agent may be considered medically necessary when the following criteria are met:Bladder Cancer.The member has recurrent or persistent carcinoma in situ of the urinary bladder(Cis).The member has experienced disease progression, intolerance or has a contraindication to BCG therapy.The member is not a candidate for immediate cystectomy.		Licensed Practitioner.	six months	
VARIZIG			Varicella Zoster: The member is using Varizig (varicella zoster immune globulin)for post-exposure prophylaxis of varicella zoster. The member is at high risk for the development of varicella zoster infection. High risk individuals include: Immunocompromised children and adults. Newborns of mothers with varicella shortly before or after delivery. Premature infants. Neonates and infants less than one year of age. Adults without evidence of immunity. Pregnant members.		Licensed Practitioner	Plan Year Duration	
VECTIBIX		Metastatic colorectal cancer	Metastatic Colorectal Cancer. Diagnosis of Metastatic (stage IV) Colorectal Cancer		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		members with RAS-mutant mCRC or for whom RAS mutation status is unknown. Member has had disease progression on Vectibix (panitumumab) or Erbitux (cetuximab).Vectibix (panitumumab) may not be used in conjunction with Erbitux(cetuximab), Tarceva (erlotinib),or Iressa (gefitinib).Vectibix (panitumumab) may not be used in conjunction with bevacizumab product (based on the results from the PACCE trial).	AND the member has mCRC that expresses verified wild-type RAS (defined as KRAS and NRAS). RAS testing should be performed for all mCRC members that are potential candidates for panitumumab or cetuximab therapy. Applies to new starts only. And one of the following applies .The member had disease progression on or following fluoropyrimidine (generally Xeloda/capecitabine/5-FU/fluorouracil), oxaliplatin, and irinotecan containing chemotherapy regimens. OR Using Vectibix (panitumumab) in combination with FOLFOX or FOLFIRI as first-line treatment OR using Vectibix (panitumumab) concurrently with irinotecan-based therapy in mCRC members.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VEKLURY			The member must have a confirmed diagnosis of COVID-19 AND The member must be hospitalized or in a healthcare setting capable of providing acute care comparable to inpatient hospital care* AND Veklury will not be coadministered with chloroquine phosphate or hydroxychloroquine sulfate AND The member must have ALL of the following laboratory testing prior to therapy initiation and during therapy as clinically appropriate: Renal (eGFR). *Skilled nursing facilities, long-term care facilities, or other similar healthcare settings are not considered capable of providing acute care comparable to inpatient hospital care (per the Summary Review of the NDA by the FDA).	The member must be 12 years of age or older and weigh at least 40 kg (88 lbs).	Licensed Practitioner	Up to 28 days or as determined through clinical review.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VELCADE		The member has experienced disease progression while on bortezomib.	Mantle Cell Lymphoma (MCL):The member has a diagnosis of Mantle Cell Lymphoma(MCL). Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib) is being used for primary therapy, therapy for previously treated disease that does not respond to primary therapy or progressive or relasped disease AND Velcade (bortezomib) is being used as monotherapy in combination with Dexamethasone or in combination with Rituxan (rituximab)		Licensed Practitioner	Plan Year Duration	
VENCLEXTA		Members that have experienced disease progression while on Venclexta (venetoclax).	Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) with or without deletion 17p and one of the following applies: has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			rituximab OR the request is for first-line therapy AND the member is using Venclexta (venetoclax) in combination with Gazyva (obinutuzumab). Mantle Cell Lymphoma: The member has a diagnosis of MCL AND the member is using Venclexta (venetoclax) as monotherapy and one of the following applies: relapsed, refractory, or progressive disease OR used after a partial response to induction therapy (and treatment goal is to achieve complete response). Acute Myeloid Leukemia: The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND one of the following applies: member is 75 years or older OR member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min). The member will be using Venclexcta (ventoclax) in combination with				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			azacitidine, or decitabine, or low-dose cytarabine.				
VENCLEXTA STARTING PACK		Members that have experienced disease progression while on Venclexta (venetoclax).	Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) with or without deletion 17p and one of the following applies: has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with rituximab OR the request is for first-line therapy AND the member is using Venclexta (venetoclax) in combination with Gazyva (obinutuzumab). Mantle Cell Lymphoma: The member has a diagnosis of MCL AND the member is using Venclexta (venetoclax) as monotherapy and one of the following applies: relapsed, refractory, or progressive disease OR used after a partial response to induction therapy (and treatment goal is to achieve complete response). Acute Myeloid Leukemia: The member has a diagnosis of newly-diagnosed acute myeloid leukemia		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(AML) AND one of the following applies: member is 75 years or older OR member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min). The member will be using Venclexcta (ventoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VENTAVIS			Pulmonary Arterial Hypertension (WHO GROUP I):The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization with WHO/NYHA Function Class IV symptoms OR the member must have had prior therapy, intolerance to, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist [e.g., Letairis (ambrisentan), Tracleer (bosentan), and Opsumit (macitentan)] approved for use in PAH.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VERASENS BLOOD GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
VERASENS METER STARTER KIT			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VERASENS TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
VERSACLOZ		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had prior therapy or intolerance to generic clozapine.		Licensed Practitioner	Plan Year Duration	
VERZENIO		Member is on concomitant palbociclib or ribociclib. Member has experienced disease	Metastatic Breast cancer—initial endocrine based therapy. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		progression on Faslodex (fulvestrant) [applies to combination therapy with Faslodex (fulvestrant)]. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, ribociclib)	The member is post-menopausal AND Verzenio (abemaciclib) is given in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine based therapy. Metastatic breast cancer combination therapy with Faslodex (fulvestrant). The member has diagnosis of advanced or metastatic hormone receptor (HR) positive human epidermal growth factor receptor 2 (HER2) negative breast cancer AND The member has experienced disease progression on endocrine therapy (e.g., anastrazole) AND Verzenio (abemaciclib) is given in combination with Faslodex (fulvestrant). Metastatic breast cancer monotherapy: The member has diagnosis of advanced or metastatic HR positive, HER2 negative breast cancer AND the member has experienced disease progression on endocrine therapy (e.g., anastrazole) and chemotherapy in the metastatic setting AND Verzenio (abemaciclib) is being used as monotherapy.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIGABATRIN			Complex Partial Seizure: Documented diagnosis of refractory complex partial seizure. Unsuccessful treatment with at least two concomitant antiepileptic drugs (AEDs) (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Infantile Spasms: Documented diagnosis of infantile spasms.		Licensed Practitioner	Plan Year Duration	
VIGADRONE			Complex Partial Seizure: Documented diagnosis of refractory complex partial seizure. Unsuccessful treatment with at least two concomitant antiepileptic drugs (AEDs) (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Infantile Spasms: Documented diagnosis of infantile spasms.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIIBRYD		Concurrent use with a MAOI or within 14 days of stopping or starting a MAOI.	The member must be utilizing Viibryd (vilazodone) for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a bupropion product (IR, SR, or XL) or mirtazapine.		Licensed Practitioner.	Plan Year Duration.	
VIMIZIM			Mucopolysaccharidosis IVA (MPS IVA Morquio A Syndrome.The member has a diagnosis of mucopolysaccharidosis IVA(MPS IVA Morquio A Syndrome)		Licensed Practitioner	plan year duration	
VISCO-3			Osteoarthritis: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND The member has had an inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices, and weight loss AND The member has had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics,		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			salicylates), or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethsaone, dexamethasone). AND The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc. Retreatment: There has been at least six months since the last treatment cycle. There is objective evidence documented in the medical record to support significant improvement in pain and functional status as a result of viscosupplementation. The member has had previous treatment, contraindication, or intolerance with Orthovisc AND Monovisc.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VISUDYNE			Age-related Macular Degeneration. Member is diagnosed with neovascular (wet) age-related macular degeneration AND member has had prior therapy, contraindication, or intolerance to bevacizumab intravitreal injection. Presumed ocular histoplasmosis. Member is diagnosed with presumed ocular histoplasmosis. Pathologic Myopia. Member is diagnosed with pathologic myopia.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VITRAKVI			Solid Tumors. Member has been diagnosed with advanced or metastatic solid tumor AND Member has a documented neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known resistance mutation AND Member is not a candidate for surgical resection AND Member is not a candidate for or does not have alternative systemic therapy treatment options. Reauthorization: Member has not developed a known resistance mutation to Vitrakvi (larotrectinib) AND Physician attestation that the member has continued to receive a clinical benefit (e.g., complete response, partial response, stable disease) and has not experienced disease progression.		Licensed Practitioner	Initial authorization: 90 days. Reauthorization: Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIVAGUARD INO GLUCOSE METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
VIVAGUARD INO SMART GLUC METER			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIVAGUARD INO TEST STRIP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
VIZIMPRO		Members on concomitant tyrosine kinase inhibitors.	Non-small cell lung cancer (NSCLC). The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following criteria applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Vizimpro (dacomitinib) as a single agent for first line therapy.		Licensed Practitioner	Six month duration	
VONVENDI					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VORICONAZOLE		VFEND/voriconazole therapy is not considered medically necessary for members with the following concomitant conditions: Concomitant use of voriconazole and high-dose ritonavir (400 mg every 12 hours), concomitant use with St. John's Wort, rifampin, carbamazepine, or long-acting barbiturates, sirolimus, CYP3A4 substrates such as terfenadine, astemizole, cisapride,	Antifungal Prophylaxis in members undergoing bone marrow transplants. Antifungal Prophylaxis in members who are intermediate or high risk of developing cancer-related fungal infections. Prophylaxis of Aspergillus species in post-heart transplantation patients should meet one of the following: CMV disease,Isolation of Aspergillus species in respiratory tract cultures,Post-transplant hemodialysis or Reoperation, Existence of an episode of invasive aspergillosis in heart transplant program two months before or after heart transplant.Prophylaxis of both Candida and Aspergillus species in high risk post-liver transplant patients should meet one of the following criteria: Local epidemiology, Renal failure needing hemodialysis or continuous venovenous dialysis pre- or post-transplantation, Reoperation involving thoracic or abdominal cavity (exploratory laparotomy, or intrathoracic surgery), Retransplantation OR Transplantation for		Licensed Practitioner	Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		pimozide, and quinidine,ergot alkaloids such as ergotamine and dihydroergotamine, rifabutin, or azole antifungals.	fulminant hepatic failure. Prophylaxis of invasive aspergillosis in post-lung transplantation,Treatment of invasive aspergillosis, Treatment of chronic cavitary or necrotizing pulmonary aspergillosis and/or Serious fungal infections cause by Scedosporium apiospermum and Fusarium spp. including Fusarium solani, in patients intolerant of other therapy OR Empiric therapy of suspected invasive Candidiasis or Aspergillosis in high risk patients with febrile neutropenia despite receiving broad-spectrum antibiotic therapy. Diagnosis of one of the following fungal infections and failed to achieve clinical response or has contraindications to fluconazole or itraconazole for sensitive (non-krusei, non-glabrata) candida infections: Esophageal candidiasis, Oropharyngeal candidiasis,Candidemia in nonneutropenic patients and/or The following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			wall, and/or wounds.				
VOSEVI		Coadministration with rifampin	Retreatment of Chronic Hepatitis C. The member must have a diagnosis of chronic hepatitis C (HCV). The member must have HCV genotype documented prior to therapy. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. The member has relapsed after completing a full course of or has a contraindication to one of the following: Genotypes 1, 4, 5, and 6: Harvoni or generic ledipasvir/sofosbuvir OR Epclusa or generic sofosbuvir/velpatasvir. Genotypes 2 and 3: The member has relapsed after completing a full course of or has a contraindication to Epclusa or generic sofosbuvir/velpatasvir.	The member must be 18 years of age or older	Licensed Practitioner.	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	
VOTRIENT		Members on concomitant tyrosine kinase	Advanced Renal Cell Carcinoma RCC).The member has a diagnosis of advanced renal cell carcinoma (stage IV). First-line therapy		Licensed Practitioner	6 month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		inhibitors. Members that have experienced disease progression while on previous pazopanib therapy.	as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology OR as subsequent therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology in members who have progressed on prior first-line therapy.Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma AND The member has progressed after prior chemotherapy.Thyroid Carcinoma:The member has a diagnosis of advanced/metastatic follicular carcinoma, Hürthlecell carcinoma, papillary or medullary carcinoma (types of thyroid carcinoma) and one of the following applies: Follicular, papillary, or Hürthle cell carcinoma are progressive and radio-iodine treatment refractory OR The member has a diagnosis of advanced medullary carcinoma and has disease progression on or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Non-Melanoma Skin Cancer. The member				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			has a diagnosis of metastatic dermatofibrosarcoma protuberans (DFSP) AND Votrient (pazopanib) will be used as a single agent. Ovarian Cancer. The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer and the disease is platinum resistant AND Votrient (pazopanib) is to be used in combination with weekly paclitaxel. Uterine Neoplasms. The member has a diagnosis of stage II, III, IV, or advanced metastatic uterine neoplasm sarcoma and disease is not suitable for primary surgery AND Votrient (pazopanib) will be used as a single agent.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VRAYLAR		Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia/ Bipolar I Disorder, manic or mixed episode:The member must be utilizing Vraylar for the treatment of schizophrenia or bipolar I disorder AND The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone or aripiprazole. Bipolar 1 Disorder (Bipolar Depression): The member must have a diagnosis of bipolar 1 disorder (bipolar depression) and the member must have documentation of previous treatment, intolerance, or contraindication to quetiapine.		Licensed Practitioner	Plan Year Duration	
VYNDAMAX			Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): The member has documentation in the medical record of wild type ATTR (ATTRwt) or a mutation in the TTR gene (e.g. Val122Ile) AND Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement	The member is 18 years of age or older.	The member is being treated by a specialist (e.g. cardiologist).	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Implanted Cardiac Device (other than a pacemaker or cardiac defibrillator), Current Pregnancy. Reauthorization: Member has evidence of slowing of clinical decline (e.g., decrease in number of hospitalizations, improvement or stabilization of the 6-minute walk test, stable or improvement in KCCQ-OS).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VYNDAQEL			Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): The member has documentation in the medical record of wild type ATTR (ATTRwt) or a mutation in the TTR gene (e.g. Val122Ile) AND Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Implanted Cardiac Device	The member is 18 years of age or older.	The member is being treated by a specialist (e.g. cardiologist).	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(other than a pacemaker or cardiac defibrillator), Current Pregnancy. Reauthorization: Member has evidence of slowing of clinical decline (e.g., decrease in number of hospitalizations, improvement or stabilization of the 6-minute walk test, stable or improvement in KCCQ-OS).				
VYVANSE		Use with monoamine oxidase (MAO) inhibitor, or within 14 days of the last MAO inhibitor dose.	Moderate to Severe Binge Eating Disoder: The member has a diagnosis of Moderate to Severe Binge Eating Disorder (BED). ADD/ADHD: The member has a diagnosis of ADHD or ADD AND the member has had previous treatment with, contraindication, or intolerance to a long-acting stimulant (e.g. methylphenidate ER).	Moderate to Severe Binge Eating Disorder (BED): 18 years of age or older. ADD/ADHD: 6 years of age or older.	Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VYXEOS		Member has experienced disease progression on Vyxeos (daunorubicin and cytarabine). Member has experienced disease progression on conventional daunorubicin and cytarabine regimen (e.g. “7+3”)	Acute Myeloid Leukemia: The member has a diagnosis of therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC) AND one of the following applies: The member has newly diagnosed disease OR the member is using Vyxeos (daunorubicin and cytarabine) as post-remission therapy (if given in induction) OR the member is using Vyxeos (daunorubicin and cytarabine) as re-induction (if given in induction).		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
WAVESENSE AMP			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
WAVESENSE JAZZ			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
WAVESENSE PRESTO			Self-Monitoring of Blood Glucose by Meter and Test Strips: A non-preferred meter and test strips for self-monitoring of blood glucose (i.e. fingerstick testing) is deemed medically necessary for member by a healthcare provider. Note: Meters and test strips marketed by Roche (e.g. AccuChek Aviva Expert, AccuChek Aviva Plus, AccuChek Nano, AccuChek SmartView) or Trividia Health (e.g. TrueMetrix, TrueTrack) are preferred.		Licensed Practitioner	Plan Year Duration	
WILATE					Licensed Practitioner	Plan Year Duration	
XALKORI		Members using Xalkori (crizotinib) for adjuvant therapy. Members taking concomitant TKIs.	Non-small Cell Lung Cancer (NSCLC).The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC)and The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease OR the member has disese which is ROS1 positive. The member will be using Xalkori (crizotinib)as monotherapy.		Licensed Practitioner	6 Months Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XATMEP		Members that are pregnant or nursing. Members with disease progression on Xatmep (methotrexate) (applies to acute lymphoblastic leukemia only).	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Xatmep (methotrexate) as part of a multi-phase, combination chemotherapy maintenance regimen AND The member has had previous treatment or intolerance to generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA): The member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) AND The member has had an insufficient therapeutic response to previous treatment, or is intolerant to, an adequate trial of first-line therapy including non-steroidal antiinflammatory agents (NSAIDs) AND The member has had previous treatment or intolerance to generic methotrexate.	The member is less than 18 years of age.	Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XCOPRI		Familial short QT syndrome.	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures AND Xcopri will be taken concomitantly with at least ONE other antiepileptic medication.	The member is 18 years of age or older.	Licensed Practitioner	Plan year duration	
XCOPRI MAINTENANCE PACK		Familial short QT syndrome.	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures AND Xcopri will be taken concomitantly with at least ONE other antiepileptic medication.	The member is 18 years of age or older.	Licensed Practitioner	Plan year duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XCOPRI TITRATION PACK		Familial short QT syndrome.	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures AND Xcopri will be taken concomitantly with at least ONE other antiepileptic medication.	The member is 18 years of age or older.	Licensed Practitioner	Plan year duration	
XELJANZ		Combination therapy with other biologics (e.g. Cosentyx, Enbrel, Humira, Kevzara, Remicade) or potent immunosuppresants (e.g. azathioprine and cyclosporine).	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. The member has had previous treatment, contraindication, or intolerance with two of the following: Humira (adalimumab), Enbrel (etanercept), Kevzara (sarilumab), or Rinvoq (upadacitinib)*. (*-Previous therapy requirements with Rinvoq do not apply to Walmart Value Rx PDP requests – Rinvoq is non-formulary on Walmart Value Rx PDP). Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member has had previous treatment, contraindication, or intolerance with two of the following: Humira (adalimumab),	The member must be 18 years of age or older.	Licensed Practitioner	RA and Psoriatic Arthritis: Plan Year Duration. UC initial approval: 4 months, reauth: Plan Year	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Enbrel (etanercept), or Cosentyx (secukinumab). Ulcerative Colitis – Initial treatment: the member has a diagnosis of moderately to severly active ulcerative colitis with a Mayo clinic score of 6 to 12 prior to therapy initiation. The member has had previous treatment, contraindication, or intolerance to one of the following conventional therapies: oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine. The member has had previous treatment, contraindication, or intolerance with Humira. Ulcerative Colitis – Continuation of treatment: The member has had a Mayo Clinic Score reduction greater than or equal to 3.				
XELODA		Members with severe renal impairment (creatinine clearance less than 30mL/min).	Colon/Colorectal Cancer.The member has a diagnosis of Stage II, Stage III or metastatic colorectal cancer (colon or rectal cancer). Breast Cancer.The member has a diagnosis of recurrent or metastatic breast cancer AND The member is using Xeloda (capecitabine) as a single agent or		Licensed Practitioner	Plan Year Duration	Neuroendocrine Tumors of Pancreas. The member has unresectable locoregional disease or distant metastatic disease and the member is experiencing with symptoms, clinically significant tumor

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			in combination with one of the following agents: trastuzumab product, Taxotere (docetaxel), Tykerb (lapatinib ditosylate) OR the member has metastatic or advanced breast cancer and all of the following apply: member has documented HER2 positive disease AND the member has received two or more prior anti-HER2 based regimens in the metastatic setting AND Nerlynx is given in combination with capecitabine OR The member has metastatic or advanced unresectable HER 2 positive breast cancer (inclusive of brain metastases) and all of the following apply: Member has received one or more prior anti-HER2 based regimen in the metastatic setting Capecitabine is given in combination with trastuzumab product and Tukysa (tucatinib) as subsequent therapy. Central Nervous System Cancer. The member has brain metastases associated with primary tumor (breast) and one of the following conditions applies: Recurrent disease (limited disease), or Recurrent stable systemic				burden, or significant progression and the member will be using Xeloda (capecitabine) in combination with Temodar (temozolomide). Ovarian Cancer. The member is using as single-agent therapy for persistense disease or recurrence.Pancreatic adenocarcinoma. The member has a diagnosis of pancreatic adenocarcinoma. Head and Neck Cancers:The member is using Xeloda (capecitabine) for recurrent, unresectable, or metastatic head and neck cancer. Anal Cancer. The member has a diagnosis of anal carcinoma and Xeloda (capecitabine) is being given in combination with mitomycin as concurrent chemoradiation.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			disease (multiple lesions). Esophageal Cancer. The member has a diagnosis of cancer of the distal esophagus or gastroesophageal junction. Gastric Cancer. The member is using Xeloda (capecitabine) as therapy for locoregional or advanced/metastatic gastric cancer. Hepatobiliary Cancers. The member has a diagnosis of hepatobiliary cancer and Xeloda (capecitabine) will be used as single agent or in combination with gemcitabine, oxaliplatin, or cisplatin for one of the following conditions: Primary treatment for unresectable or metastatic disease or in concurrent chemoradiation.				
XGEVA		Uncorrected Pre-existing hypocalcemia. Concurrent use of bisphosphonate therapy (e.g., zoledronic acid, pamidronate)	Osteolytic Bone Metastases of Solid Tumors. The member has a diagnosis of solid tumor cancer (such as breast cancer, prostate cancer, or other solid tumor). The member must have documented bone metastases. The member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid or		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			pamidronate (disease progression, intolerance or contraindication following treatment with pamidronate or zoledronic acid does not apply for prostate cancer). Multiple Myeloma: The member has a diagnosis of multiple myeloma AND the member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid or pamidronate. Giant Cell tumor of Bone: Diagnosis of giant cell tumor of bone. Hypercalcemia of malignancy: The member has hypercalcemia of malignancy, defined as an albumin-corrected calcium of greater than 12.5 mg/dL AND The member has had prior therapy with intravenous bisphosphonate therapy (e.g. pamidronate or zoledronic acid).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XIFAXAN		Prevention of traveler's diarrhea. Treatment of traveler's diarrhea caused by pathogens other than E.Coli. Treatement of traveler's diarrha complicated by fever or bloody stools.	Travelers diarrhea: Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli. Member has previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, or azithromycin. Hepatic encepalopathy prophylaxis: Member must have hepatic encephalpathy. Member has previous treatment, intolerance or contraindication to lactulose or neomycin. Irritable bowel syndrome with diarrhea (IBS-D): Diagnosis of Irritable bowel syndrome with diarrhea (IBS-D).	Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D.	Licensed Practitioner.	Plan year for Hepatic Encepalopathy,30 days for traveler's diarrhea and 3 months for IBS-D.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XOFIGO		Members who have experienced disease progression on Xofigo (radium Ra 223 dichloride). Concomitant Xtandi (enzalutimide) or Zytiga (abiraterone acetate) is not recommended at this time due to lack of evidence supporting safe and effective use.	Prostate Cancer: The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC)AND The member has symptomatic bone metastases AND The member has no known visceral metastatic disease.		Licensed Practitioner	Six month duration	
XOLAIR			Chronic Idiopathic Urticaria. Member has a diagnosis of chronic idiopathic urticaria. Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated. Member will continue to receive H1 antihistamine therapy while on Xolair,unless contraindicated. Diagnosis of	The patient is 12 years of age or older for diagnosis of chronic idiopathic urticaria. The patient is 6 years of age or older for moderate to severe persistent	Licensed Practitioner	Plan Year	Continuation of therapy: Member is currently stable on Xolair therapy. Member will continue on asthma controller inhalers: inhaled corticosteroids with or without a long-acting beta2-agonist (e.g. Flovent

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			moderate or severe persistent asthma, FEV1, allergic sensitivity skin or blood test, baseline serium IgE. Omalizumab may be considered medically necessary when the following criteria are met for the following indication: Moderate or Severe persistent asthma. The patient has a diagnosis of moderate or severe persistent asthma.The patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial aeroallergen. For ages 12 and older, patient must have a baseline serum IgE between 30 IU/ml and 700 IU/ml. For ages 6 years old to less than 12 years old: must have baseline serum IgE between 30 IU/ml and 1300 IU/ml. The patient has inadequately controlled asthma despite the use of: Inhaled Corticosteroids.	asthma.			HFA/Diskus, Arnuity Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicrt HFA, Dulera HFA, Asmanex HFA, Asmanex Twisthaler).

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XOSPATA		The member has experienced disease progression while on FLT3 inhibitors.	Acute Myeloid Leukemia. The member has a diagnosis of acute myeloid leukemia AND The member has relapsed or refractory disease AND The member has documented FLT3 mutation positive disease AND The member will be using Xospata (gilteritinib) as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XPOVIO		The member has experienced disease progression on Xpovio (selinexor).	Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member has received at least four prior therapies AND The member's disease is refractory to at least two proteasome inhibitors (e.g. bortezomib, carfilzomib), at least two immunomodulatory agents (e.g. lenalidomide, pomalidomide) and an anti-CD38 monoclonal antibody (e.g. daratumumab) AND The member will be using Xpovio (selinexor) in combination with dexamethasone. Diffuse large B-cell lymphoma: The member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma AND The member has received at least two prior lines of systemic therapy AND The member will be using Xpovio (selinexor) as monotherapy.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XTANDI		Concomitant use with Erleada (apalutamide), abiraterone acetate,Provenge(sipuleucel-T),Taxotere(docetaxel)or Jevtana(cabazitaxel)is not recommended at this time due to lack of evidence supporting safety and efficacy. Members that have experienced disease progression while on Xtandi (enzalutamide).	Prostate Cancer (metastatic castration-resistant). The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC). Prostate Cancer (non-metastatic castration-resistant). The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND The member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog). Prostate Cancer (metastatic castration-sensitive): the member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog).		Licensed Practitioner	6 months duration	
XYNTHA					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XYNTHA SOLOFUSE					Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XYREM		Succinic semialdehyde dehydrogenase deficiency. Concomitant use with sedative hypnotic drugs.	Narcolepsy with Cataplexy: The member has a diagnosis of narcolepsy with cataplexy. Reauthorization: Documentation must be provided demonstrating a reduction in frequency of cataplexy attacks associated with Xyrem therapy. Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy with excessive daytime sleepiness AND previous treatment, intolerance, or contraindication to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release, or dextroamphetamine) and modafinil. Prerequisite therapy required only for diagnosis of narcolepsy with excessive daytime sleepiness. Reauthorization: Documentation must be provided demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy.		Licensed Practitioner.	Initial authorization: 3 months. Reauthorization: Plan Year Duration.	
YERVOY		Concomitant	Melanoma.The member has a diagnosis of		Licensed	4 Months	Microsatellite Instability-High

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Zelboraf (vemurafenib), Tafinlar (dabrafenib), Cotellic (cobimetnib) or Mekinist (trametinib) therapy. The member has had progression of disease on adjuvant therapy with Yervoy (ipilimumab).	unresectable or metastatic melanoma OR Adjuvant treatment of cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 millimeter who have undergone complete resection, including total lymphadenectomy. The member is naive to Yervoy (ipilimumab).The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.Melanoma - Reauthorization Criteria Melanoma.The member had stable disease, partial response or complete response for greater than 3 months following the completion of initial induction (completion of four cycles within a 16 week period. Members who were unable to tolerate or receive the complete induction regimen within 16 weeks of initiation will not receive approval). AND The member has progressive disease, necessitating reinduction therapy with Yervoy (ipilimumab). AND The member has an Eastern Cooperative Oncology Group		Practitioner	Duration	(MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer. The member has a diagnosis of unresectable or metastatic colorectal cancer with documented microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab) AND One of the following applies: The member has disease that has progressed following treatment with oxaliplatin-, irinotecan-, or fluoropyrimidine-based therapy OR The member has unresectable metachronous metastases and previously received adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(ECOG) performance status of 0-2. Reauth adjuvant treatment of cutaneous melanoma. The member has not had disease recurrence or unacceptable toxicity with Yervoy (ipilimumab) AND The total duration of treatment is less than 3 years AND The member has an ECOG performance status of 0-2. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma (RCC) AND The member has intermediate or poor risk disease, based on International Metastatic Renal Cell Carcinoma Database Consortium (IMDC) Criteria AND The member has predominant clear cell histology AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab) AND The member will be using for first line therapy.				(capecitabine and oxaliplatin) within the past 12 months. Hepatocellular carcinoma: The member has a diagnosis of hepatocellular carcinoma AND The member has been previously treated with Nexavar (sorafenib) AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab). Non-small cell lung cancer (NSCLC) -- First Line Therapy: The member must have a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND one of the following applies: Disease with PD-L1 expression greater than or equal to 1% with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Tumor expresses PD-L1 as determined by an FDA-

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							approved test AND Will be used in combination with Opdivo (nivolumab) OR Disease with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Will be used in combination with Opdivo (nivolumab) AND Will be used in combination with two cycles of platinum doublet chemotherapy.
YESCARTA		The member has received prior CD-19 targeted therapy. The member has received prior CD-19 targeted CAR-T cell therapy (e.g. tisagenlecleucel). The member has active hepatitis B (HBs AG-positive)	Large B-cell Lymphoma: The member has a diagnosis of large B-cell lymphoma [i.e. diffuse large B-cell lymphoma (DBLCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma] AND The member has had two or more lines of previous systemic therapy including anti- CD-20 monoclonal antibody (e.g. rituximab) and an anthracycline AND For DLBCL arising from follicular lymphoma, must have	The member is greater than or equal to 18 years of age	Licensed Practitioner	60 days duration or as determined through clinical review. A maximum of one dose per lifetime.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		or hepatitis C infection. The member has HIV/AIDs. The member has a diagnosis of primary central nervous system lymphoma. The member has received prior allogeneic transplant.	received prior chemotherapy for follicular lymphoma and subsequently have chemorefractory disease after transformation to DLBCL AND the member has relapsed or refractory disease, defined as one of the following: Best response to the most recent regimen was progressive disease or stable disease and relapse is occurring within 6 months from last dose OR Disease progression or recurrence less than or equal to 12 months after prior autologous stem cell transplant (ASCT) AND The member will be using Yescarta in conjunction with lymphodepleting chemotherapy (fludarabine 30 mg/m2 daily for 3 days and cyclophosphamide 500 mg/m2 daily for 3 days) AND The member will be using Yescarta (axicabtagene ciloleucel) at a treatment center that is certified to administer Yescarta(axicabtagene ciloleucel)				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
YONDELIS		Member experiences disease progression on Yondelis (trabectedin)	Liposarcoma/Leiomyosarcoma:The member has unresectable or metastatic liposarcoma or leiomyosarcoma AND The member has received prior anthracycline (e.g., doxorubicin) containing regimen. Soft Tissue Sarcoma. Yondelis (trabectedin) will be used as monotherapy for palliative treatment and one of the following applies: The member has a diagnosis of unresectable or progressive retroperitoneal or intraabdominal soft tissue sarcoma OR the member has a diagnosis of angiosarcoma or rhabdomyosarcoma OR the member has a diagnosis stage IV soft tissue sarcoma of the extremity/superficial trunk, head/neck, or recurrent disease with disseminated metastases.		Licensed Practitioner	six month duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
YUTIQ		Active ocular or periocular infections	Chronic Non-infectious Uveitis. Member has a diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye. Member has had previous treatment with at least a 28-day course of a systemic immunosuppressive agent and did not have a clinically meaningful improvement in symptoms.		Licensed Practitioner	Plan year duration	
ZALTRAP		Members receiving concomitant therapy with bevacizumab product. The member has experienced disease progression while on Zaltrap.	Metastatic Colorectal Cancer: The member has a diagnosis of metastatic colorectal cancer AND The member is using Zaltrap in combination with irinotecan or FOLFIRI (leucovorin, irinotecan, 5-fluorouracil) chemotherapy AND At least one of the following applies: Zaltrap is being used as second line therapy AND The member experienced disease progression or resistance with an Oxaliplatin containing regimen OR The member has unresectable metachronous metastases and has received previous adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX(capecitabine and oxaliplatin)		Licensed Practitioner	Six months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZARXIO		Same day administration with myelosuppressive chemotherapy or therapeutic radiation. Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgastrim-sndz or filgastrim-aafi), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g.	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy. The patient must have a diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to starting (filgrastim-sndz) injections. The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) is greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors), OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen AND one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or greater than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours),		Licensed Practitioner	4 months duration	Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic. The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Febrile Neutropenia Prophylaxis, in non-myeloid malignancies following progenitor-cell transplantation: The member must have had a peripheral-blood progenitor cell (PBPC) transplantation for non-myeloid malignancy. Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose).	Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR Receiving a dose-dense chemotherapy regimen. Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia. The member must have a diagnosis of febrile neutropenia AND Zarxio (filgrastim-sndz) must be used in adjunct with appropriate antibiotics in high risk members.				chemotherapy. The member must have a diagnosis of acute myeloid leukemia (AML) and the member must be receiving either induction chemotherapy OR consolidation chemotherapy.
ZEJULA		Members that have experienced disease progression while on or following	Ovarian cancer: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines		Licensed Practitioner.	6 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].	of platinum based chemotherapy AND The member is in complete or partial response to their last platinum reigmen AND The member will utilize Zejula (niraparib) as a monotherapy. *Discontinue Avasatin before initiating maintenance therapy with Zejula. Ovarian Cancer - Fourth Line Treatment: The member has a diagnosis of advanced ovarian, fallopian tube, or primary peritoneal cancer AND the member's disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation OR genomic instability and progression more than six months after response to last platinum-based chemotherapy. AND the member has been treated with three or more prior lines of chemotherapy. Ovarian Cancer – First line maintenance therapy: member has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer AND member is in complete response or partial response				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			to first line treatment with platinum based chemotherapy AND member will utilize Zejula (niraparib) capsules as monotherapy.				
ZELBORAF		Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Tafinlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while	Melanoma: The member has a diagnosis of Unresectable or Stage IV Metastatic melanoma.The member has a documented BRAF V600 activating mutation.The member will be using Zelboraf (vemurafenib) as monotherapy OR in combination with Cotellic (cobimetnib). Erdheim-Chester Disease: The member has a diagnosis of Erdheim-Chester Disease AND The member has a documented BRAF V600 mutation AND The member will be using Zelboraf (vemurafenib) as monotherapy.		Licensed Practitioner	6 months duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on Zelboraf (vemurafenib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)].					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZEPZELCA		Member experiences disease progression on Zepzelca (lurbinectedin).	Small cell lung cancer: The member has a diagnosis of metastatic small cell lung cancer AND The member had progression on or after treatment with platinum-based chemotherapy AND Zepzelca (lurbinectedin) will be used as a single agent.		Licensed Practitioner	6 Months Duration	
ZEVALIN (Y-90)		Members that have received previous radioimmunotherapy with Zevalin (ibritumomab tiuxetan).	The member has relapsed or refractory, low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL) OR The member has previously untreated (radioimmunotherapy) follicular NHL and achieved a partial or complete response to first-line chemotherapy.		Licensed Practitioner	1 month Duration	
ZIEXTENZO		Concomitant use (within seven days of Ziextenzo (pegfilgrastim-bmez) dose) with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi),	Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g.breast cancer, lung cancer) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than		Licensed Practitioner	4 months duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		tbo-filgrastim or sargramostim. Same day administration with myelosuppressive chemotherapy or therapeutic radiation. Cannot be given more than once per chemotherapy cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZIRABEV		Used in lung cancer members that have small cell or squamous cell disease, recent hemoptysis, history of bleeding, continuing anticoagulation, or as a single agent (unless maintenance as described in Coverage Determinations). Should not be initiated in members with recent hemoptysis. Should not be used in members who experience a severe arterial thromboembolic event. Should not	Metastatic colorectal cancer: Diagnosis of metastatic colorectal cancer AND one of the following apply: Member is using bevacizumab in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemotherapy for first or second-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line therapy in patients who have progressed on first-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). Member has NSCLC with non-squamous cell histology AND Member is using bevacizumab in combo with cisplatin or carboplatin based regimens for unresectable, locally advanced, recurrent, or metastatic NSCLC AND One of the following apply: using for first line therapy OR as subsequent therapy immediately after one of the following situations: EGFR mutation-positive tumors after prior therapy with erlotinib, afatinib, or gefitinib (if cytotoxic therapy not		Licensed Practitioner	6 Months Duration	Stage IV/Metastatic (Unresectable) RCC. Member has RCC and member is using bevacizumab to treat stage IV unresectable kidney cancer in combination with interferon alpha OR member is using bevacizumab as systemic therapy for non-clear cell histology. Recurrent Primary CNS Tumor (including Glioblastoma multiforme).The member has a diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND Bevacizumab is being used as a single agent or in combination with irinotecan, carmustine, lomustine or temozolomide. The member does not have a CNS hemorrhage. Cervical Cancer: The member has recurrent, or metastatic cervical cancer

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		be used in members with gastrointestinal perforation. Bevacizumab should not be used in members with fistula formation involving internal organs. Bevacizumab should not be used in members experiencing a hypertensive crisis or hypertensive encephalopathy. Bevacizumab should not be used for at least 28 days following major surgery or until surgical incision is fully healed. Bevacizumab may	previously not given) OR ALK-positive tumors after prior therapy with crizotinib or ceritinib, or alectinib or brigatinib (if cytotoxic therapy not previously not given) OR ROS-1 positive disease after prior therapy with crizotinib (if cytotoxic therapy not previously not given) OR Pembrolizumab (with PD-L1 expression of greater than 1%) administered as first line therapy and EGFR, ALK, BRAF V600E, and ROS1 negative tumors (if cytotoxic therapy not previously not given) OR member has BRAF V600E positive disease OR member is using bevacizumab as single-agent continuation maintenance therapy if bevacizumab was used as first line treatment for recurrence or metastasis OR member has disease with no EGFR or ALK genomic tumor aberrations AND bevacizumab will be given in combo with carboplatin and paclitaxel and Tecentriq as first line therapy followed by maintenance therapy with combo Tecentriq and bevacizumab.				AND Bevacizumab will be used in combination (if not previously used as first line therapy) with paclitaxel and cisplatin or carboplatin and paclitaxel or paclitaxel and topotecan as first line therapy.

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		not be used in conjunction with Vectibix. Bevacizumab may not be used in conjunction with Erbitux. Bevacizumab may not be used in the adjuvant or neoadjuvant setting. Bevacizumab should not be continued or restarted after disease progression with the exception of metastatic colorectal cancer.					

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZOLADEX		Zoladex should not be continued or restarted after malignant disease progression(Exception is Prostate Cancer). Concomitant use with other LHRH agents. Abnormal vaginal bleeding of unknown etiology.	Prostate Cancer. The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Breast Cancer. The patient must be pre- or perimenopausal. The patient must have a diagnosis of hormone receptor (ER and/or PR +) positive breast cancer. Endometriosis. The patient must have a diagnosis of endometriosis. The patient has had an inadequate pain control response or intolerance to: Danazol,Combination Oral Contraceptives, Progesterone Only Products.Endometrial Thinning. The patient is scheduled for endometrial ablation.	The member must be 18 years or older.	Licensed Practitioner	2 months for endometrial hyperplasia	Approval Durations. Advanced Prostate Cancer or Invasive Breast Cancer is 12 months. Endometriosis is six months. Endometrial Hyperplasia is two months
ZOLEDRONIC ACID-MANNITOL-WATER		Severe renal impairment (creatinine clearance less than 35 mL/min). Evidence of acute renal failure.Patients with	Osteoporosis: The member has a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Osteoporosis Prophylaxis in		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Hypocalcemia.	postmenopausal members: The member is postmenopausal. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Glucocorticoid induced Osteoporosis in men and women taking systemic glucocorticoids: Diagnosis of glucocorticoid induced osteoporosis or is either initiating or continuing systemic glucocorticoids with a daily dosage equivalent of 7.5 mg or greater of prednisone and is expected to remain on glucocorticoids for at least 12 months AND has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Paget's Disease: Diagnosis of Paget's disease. The member has continued elevation(s) in serum alkaline phosphatase (SAP) of two				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			times or higher than the upper limit of normal despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, PAMIDRONATE). And the member: Is symptomatic OR is at risk for complications from their disease, to induce remission, or to normalize serum alkaline phosphatase. Brand Reclast request only: Members must have previous treatment, contraindication, or intolerance to generic Zoledronic acid (generic Reclast).				

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZOLGENSMA			Spinal Muscular Atrophy: The member has a genetically confirmed diagnosis of SMA with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene AND The member has no more than 4 SMN2 copy numbers AND The member has an anti-AAV9 antibody titer of less than or equal to 1:50 AND The member does not have a contraindication or intolerance to corticosteroids AND The member does not have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence) AND The member is being treated by a specialist (e.g. neurologist) AND The request for therapy is supported with laboratory testing (e.g. confirming diagnosis and anti-AAV9 antibody titer) and medical records or chart notes.	The member is less than 2 years of age.	Licensed Practitioner	One Lifetime Dose	
ZOLINZA		Members that have experienced disease progression while on Zolinza (vorinostat).	Cutaneous T-Cell Lymphoma (CTCL).The member has a diagnosis of progressive, persistent, or recurrent disease or The member hwill be using Zolinza as primary treatment or adjuvant therapy.		Licensed Practitioner	Plan Year Duration	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZULRESSO			Post-Partum Depression: The member is an adult with a clinical diagnosis of major depressive disorder (MDD) in the third trimester of pregnancy or within 4 weeks of delivery as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. HAM-D, MADRS, PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item). The member has previous treatment, contraindication, or intolerance to at least one antidepressant from the following: generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline), SNRI (e.g., venlafaxine or duloxetine), buproprion OR mirtazapine. The member is not pregnant and not more than 6 months post-partum at initiation of Zulresso (brexanolone) therapy. The member is not experiencing active psychosis and does not have a history of bipolar disorders, schizophrenia, and/or schizoaffective disorder. The member has not attempted suicide in the current episode of postpartum	The member is at least 18 years of age.	Licensed Practitioner	60 days duration.	

Drug Name	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			depression.				
ZYDELIG		The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib).	Chronic Lymphocytic Leukemia (CLL): The member must have a diagnosis of relapsed OR refractory chronic lymphocytic leukemia (CLL) or relapsed OR refractory small lymphocytic lymphoma (SLL). Follicular Lymphoma (FL): The member must have a diagnosis of relapsed follicular lymphoma (FL) AND The member must have received at least one prior systemic therapy AND The member will be using Zydelig (idelalisib) as monotherapy.		Licensed Practitioner	Plan Year Duration	
ZYKADIA			Non-small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic and documented anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) AND The member will be using Zykadia (ceritinib) as monotherapy AND Zykadia (ceritinib) is being used as first-line therapy OR as subsequent therapy following disease progression on first line therapy with Xalkori (crizotinib) or Alecensa (alectinib).		Licensed Practitioner.	6 months duration.	

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
ADRUCIL 500 MG/10 ML VIAL	Dacogen 50 mg intravenous solution	Halaven 1 mg/2 mL (0.5 mg/mL) intravenous solution	MORPHINE 4 MG/ML CARPUJECT	Sandostatin 100 mcg/mL injection solution
Aminosyn 8.5 % intravenous solution	Desferal 500 mg solution for injection	HYDROMORPHONE 4 MG/ML VIAL	MYCOPHENOLATE 500 MG TABLET	Skyla 14 mcg/24 hrs (3 yrs) 13.5 mg intrauterine device
CYCLOPENTOLATE 1% EYE DROPS	Gamunex-C 20 gram/200 mL (10 %) injection solution	MILRINONE-D5W 40 MG/200 ML	Remodulin 1 mg/mL injection solution	Zulresso 5 mg/mL intravenous solution
Aranesp 100 mcg/mL (in polysorbate) Injection	DOPAMINE 160 MG/ML VIAL	HyQvia IG Component 30 gram/300 mL (10 %) subcutaneous solution	Neulasta Onpro 6 mg/0.6 mL with wearable subcutaneous injector	TACROLIMUS 1 MG CAPSULE
CLOFARABINE 20 MG/20 ML VIAL	Fusilev 50 mg intravenous solution	Medrol 4 mg tablet	Pulmicort 0.5 mg/2 mL suspension for nebulization	Zemaira 1,000 mg intravenous solution
Atgam 50 mg/mL intravenous solution	Duramorph (PF) 0.5 mg/mL injection solution	Inflectra 100 mg intravenous solution	OCTREOTIDE ACET 100 MCG/ML SYR	TOPOTECAN HCL 4 MG/4 ML VIAL
Bethkis 300 mg/4 mL solution for nebulization	Empliciti 400 mg intravenous solution	IRINOTECAN HCL 300 MG/15 ML VL	Opdivo 100 mg/10 mL intravenous solution	Trodelvy 180 mg intravenous solution
Camptosar 300 mg/15 mL intravenous solution	Erwinaze 10,000 unit solution for injection	Kyprolis 60 mg intravenous solution	Panzyga 10 % intravenous solution	Velcade 3.5 mg solution for injection
Cyclogyl 0.5 % eye drops	Gammaked 5 gram/50 mL (10 %) injection solution	METHYLPREDNISOLONE 8 MG TAB	Recombivax HB (PF) 10 mcg/mL intramuscular suspension	ZOMETA 4 MG/100 ML INJECTION

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CISPLATIN 50 MG/50 ML VIAL	FENTANYL 250 MCG/5 ML AMPUL	Libtayo 50 mg/mL intravenous solution	PREDNISONE 5 MG/5 ML SOLUTION	WinRho SDF 2,500 unit (500 mcg)/2.2 mL injection solution
ALBUTEROL 2.5 MG/0.5 ML SOL	DAUNORUBICIN 50 MG/10 ML VIAL	Herceptin Hylecta 600 mg-10,000 unit/5 mL subcutaneous solution	MORPHINE 8 MG/ML CARPUJECT	Sarclisa 20 mg/mL intravenous solution
Clinimix 4.25 % in 5 % dextrose Sulfite Free intravenous solution	Flebogamma DIF 10 % intravenous solution	Lumizyme 50 mg intravenous solution	Prialt 25 mcg/mL intrathecal solution	Xeomin 100 unit intramuscular solution
Clinimix 8 % in 10 % dextrose (sulfite-free) intravenous solution	FLUDARABINE 50 MG/2 ML VIAL	Lupron Depot 30 mg (4 month) intramuscular syringe kit	Procrit 2,000 unit/mL injection solution	Xiaflex 0.9 mg solution for injection
Aranesp 25 mcg/mL (in polysorbate) Injection	DOPAMINE 80 MG/ML VIAL	IDARUBICIN HCL 20 MG/20 ML VL	Nivestym 300 mcg/0.5 mL subcutaneous syringe	Temodar 100 mg intravenous solution
Crysvita 30 mg/mL subcutaneous solution	GamaSTAN S/D 15 %-18 % range intramuscular solution	Mepsevii 2 mg/mL intravenous solution	Rapamune 1 mg/mL oral solution	ZOFRAN 4 MG/5 ML ORAL SOLN
CALCIUM GLUC 10,000 MG/100 ML	Epogen 3,000 unit/mL injection solution	Khapzory 175 mg intravenous solution	PALONOSETRON HCL 0.25 MG/5 ML	Valstar 40 mg/mL intravesical solution
ACYCLOVIR 1,000 MG/20 ML VIAL	CYCLOSPORINE MODIFIED 100 MG	GEMCITABINE HCL 200 MG VIAL	MITOMYCIN 40 MG VIAL	RETAVASE VIAL HALF-KIT
Adriamycin 10 mg intravenous solution	CYTARABINE 100 MG/5 ML VIAL	Givlaari 189 mg/mL subcutaneous solution	MORPHINE 10 MG/0.7 ML AUTO-INJ	ROMIDEPSIN 10 MG KIT

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CLINIMIX E 4.25%-25% SOLUTION	FLUOROURACIL 5 GM/100 ML VIAL	Lupron Depot-Ped 7.5 mg (Ped) intramuscular kit	Prograf 0.2 mg oral granules in packet	Xopenex 1.25 mg/3 mL solution for nebulization
Bendeka 25 mg/mL intravenous solution	Emend 125 mg (1)-80 mg (2) capsules in a dose pack	Intron A 18 million unit (1 mL) solution for injection	ONDANSETRON ODT 4 MG TABLET	Trexall 5 mg tablet
Cinvanti 7.2 mg/mL intravenous emulsion	FENTANYL 100 MCG/2 ML CARPUJCT	LEVOLEUCOVORIN 175 MG/17.5 ML	PREDNISONE 2.5 MG TABLET	Vyxeos 44 mg-100 mg intravenous solution
Astagraf XL 0.5 mg capsule,extended release	DRONABINOL 2.5 MG CAPSULE	Imovax Rabies Vaccine (PF) 2.5 unit intramuscular solution	OCTREOTIDE 5,000 MCG/5 ML VIAL	Toposar 20 mg/mL intravenous solution
Compazine 10 mg tablet	Gablofen 20,000 mcg/20 mL (1,000 mcg/mL) intrathecal solution	MELPHALAN 50 MG VIAL W-DILUENT	Qutenza 8 % topical kit	Zilretta 32 mg intra-articular suspension,extended release
ACETYLCYSTEINE 10% VIAL	CYCLOPHOSPHAMIDE 50 MG CAPSULE	Gazyva 1,000 mg/40 mL intravenous solution	Mircera 50 mcg/0.3 mL injection syringe	Retacrit 10,000 unit/mL injection solution
CellCept 200 mg/mL oral suspension	EVEROLIMUS 0.25 MG TABLET	LEUCOVORIN CALCIUM 350 MG VIAL	Perjeta 420 mg/14 mL (30 mg/mL) intravenous solution	VINBLASTINE 1 MG/ML VIAL
CHLORPROMAZINE 10 MG TABLET	Fabrazyme 5 mg intravenous solution	LEUPROLIDE 2WK 14 MG/2.8 ML VL	Polivy 30 mg intravenous solution	VINORELBINE 50 MG/5 ML VIAL
Aminosyn II 8.5 % with electrolytes intravenous solution	Dilaudid (PF) 1 mg/mL injection syringe	HYDROXYPROGESTERONE 1.25 G/5ML	Myfortic 360 mg tablet,delayed release	Somatuline Depot 60 mg/0.2 mL subcutaneous syringe

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Avsola 100 mg intravenous solution	Dysport 300 unit intramuscular solution	Infugem 1,400 mg/140 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 50 MCG/ML AMP	TRANEXAMIC ACID 1,000 MG/10 ML
Aranesp 200 mcg/0.4 mL (in polysorbate) injection syringe	DOPAMINE 400 MG-D5W 500 ML	IBANDRONATE 3 MG/3 ML VIAL	Neupogen 480 mcg/0.8 mL injection syringe	Taxotere 80 mg/4 mL (20 mg/mL) intravenous solution
CLINIMIX N9G20E 2.75%-D10W SOL	Freamine III 10 % intravenous solution	Medrol 16 mg tablet	Prolia 60 mg/mL subcutaneous syringe	Zanosar 1 gram intravenous solution
Blenrep 100 mg intravenous solution	Engerix-B Pediatric (PF) 10 mcg/0.5 mL intramuscular syringe	Isopto Atropine 1 % eye drops	Orencia (with maltose) 250 mg intravenous solution	TROPICAMIDE 0.5% EYE DROP
Cyclomydril 0.2 %-1 % eye drops	Gamunex-C 1 gram/10 mL (10 %) injection solution	MILRINONE LACT 20 MG/20 ML VL	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular suspension	Zortress 0.5 mg tablet
Clinimix 5 % in 20 % dextrose (sulfite-free) intravenous solution	Flolan 1.5 mg intravenous solution	Lupron Depot 11.25 mg (3 month) intramuscular syringe kit	PROCHLORPERAZINE 10 MG TAB	Xerava 100 mg intravenous solution
Aralast NP 500 mg intravenous solution	DOCETAXEL 200 MG/10 ML VIAL	HyQvia IG Component 10 gram/100 mL (10 %) subcutaneous solution	Neoral 25 mg capsule	Synribo 3.5 mg subcutaneous solution
Aranesp 40 mcg/0.4 mL (in polysorbate) injection syringe	Doxil 2 mg/mL intravenous suspension	Ifex 3 gram intravenous solution	Nivestym 480 mcg/1.6 mL injection solution	Tepadina 100 mg solution for injection
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	GANCICLOVIR 500 MG VIAL			

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
ALBUTEROL SUL 0.63 MG/3 ML SOL	DEFEROXAMINE 500 MG VIAL	Hizentra 1 gram/5 mL (20 %) subcutaneous solution	MORPHINE SULFATE 1 MG/ML VIAL	Signifor 0.9 mg/mL (1 mL) subcutaneous solution
BUDESONIDE 0.25 MG/2 ML SUSP	EPIRUBICIN HCL 200 MG VIAL	Kalbitor 10 mg/mL (1 mL) subcutaneous solution	PACLITAXEL 30 MG/5 ML VIAL	Tyvaso Refill Kit 1.74 mg/2.9 mL (0.6 mg/mL) solution for nebulization
Akynzeo (netupitant) 300 mg-0.5 mg capsule	Darzalex Faspro 1,800 mg-30,000 unit/15 mL subcutaneous solution	Hepatamine 8% intravenous solution	MORPHINE 5 MG/10 ML VIAL	Sandostatin LAR Depot 10 mg intramuscular susp,extended release
ACYCLOVIR SODIUM 500 MG VIAL	CYCLOSPORINE MODIFIED 50 MG	Gengraf 100 mg capsule	MITOXANTRONE 25 MG/12.5 ML VL	Rituxan 10 mg/mL concentrate,intravenous
CLINIMIX E 2.75%-10% SOLUTION	FLUOROURACIL 2.5 GM/50 ML BTL	Lupron Depot-Ped 11.25 mg intramuscular kit	Procrit 3,000 unit/mL injection solution	Xolair 75 mg/0.5 mL subcutaneous syringe
Aldurazyme 2.9 mg/5 mL intravenous solution	Demerol (PF) 100 mg/mL injection syringe	Hizentra 2 gram/10 mL (20 %) subcutaneous solution	MORPHINE SULFATE 4 MG/ML VIAL	Signifor LAR 30 mg intramuscular suspension
BUSULFAN 60 MG/10 ML VIAL	Epogen 2,000 unit/mL injection solution	Kanuma 2 mg/mL intravenous solution	Padcev 30 mg intravenous solution	Unituxin 3.5 mg/mL intravenous solution
Beleodaq 500 mg intravenous solution	Ellence 50 mg/25 mL intravenous solution	Intralipid 30 % intravenous emulsion	ONDANSETRON HCL 24 MG TABLET	TREPROSTINIL 50 MG/20 ML VIAL
Cimzia Powder for Recon 400 mg (200 mg x 2 vials) subcutaneous kit	Fensolvi 45 mg subcutaneous syringe	LEVALBUTEROL 1.25 MG/3 ML SOL	Poteligeo 4 mg/mL intravenous solution	VPRIV 400 unit intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Arzerra 1,000 mg/50 mL intravenous solution	DOXORUBICIN LIPOSOME 20MG/10ML	Imlygic 10exp6 (1 million) PFU/mL suspension for injection	Octagam 5 % intravenous solution	TOBRAMYCIN 300 MG/4 ML AMPULE
Caldolor 800 mg/200 mL (4 mg/mL) intravenous piggyback	EPOPROSTENOL SODIUM 1.5 MG VL	Kyleena 17.5 mcg/24 hrs (5yrs) 19.5mg intrauterine device	PAMIDRONATE 90 MG/10 ML VIAL	Varubi 90 mg tablet
APREPITANT 40 MG CAPSULE	DOCETAXEL 160 MG/8 ML VIAL	HyQvia HY Component 200 unit/1.25 mL subcutaneous solution	NebuSal 6 % solution for nebulization	Synagis 100 mg/mL intramuscular solution
Benlysta 200 mg/mL subcutaneous syringe	Emend 40 mg capsule	IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	Onpattro 2 mg/mL intravenous solution	TRIMETHOBENZAMIDE 300 MG CAP
Actemra 400 mg/20 mL (20 mg/mL) intravenous solution	CYCLOSPORINE 100 MG CAPSULE	GEMCITABINE 200 MG/5.26 ML VL	Mitigo (PF) 10 mg/mL injection solution	Retacrit 3,000 unit/mL injection solution
AMIFOSTINE 500 MG VIAL	Demerol 50 mg/mL injection solution	HYDROMORPHONE 1 MG/ML VIAL	Mvasi 25 mg/mL intravenous solution	SIROLIMUS 1 MG TABLET
Aminosyn-PF 10 % intravenous solution	DOBUTAMINE 1,000 MG/250 ML D5W	HyperTET S/D (PF) 250 unit intramuscular syringe	Myobloc 2,500 unit/0.5 mL intramuscular solution	Spravato 28 mg nasal spray
Azasan 100 mg tablet	Elelyso 200 unit intravenous solution	Infugem 1,700 mg/170 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 500 MCG/ML AMP	Treanda 100 mg intravenous powder for solution
Aminosyn II 15 % intravenous solution	Dextenza 0.4 mg intracanalicular insert	HYDROMORPHONE HCL 4 MG/ML AMP	MYCOPHENOLIC ACID DR 360 MG TB	SODIUM CHLORIDE 10% VIAL

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CellCept Intravenous 500 mg intravenous solution	Evomela 50 mg intravenous solution	Leukine 250 mcg solution for injection	Photofrin 75 mg intravenous solution	VINCRISTINE 1 MG/ML VIAL
CROMOLYN 20 MG/2 ML NEB SOLN	Gablofen 40,000 mcg/20 mL (2,000 mcg/mL) intrathecal syringe	MEPERIDINE 100 MG/ML VIAL	Radicava 30 mg/100 mL intravenous piggyback	Zinplava 25 mg/mL intravenous solution
Clinisol SF 15 % intravenous solution	Fulphila 6 mg/0.6 mL subcutaneous syringe	Medrol 2 mg tablet	Prosol 20 % intravenous solution	Zarxio 300 mcg/0.5 mL injection syringe
CYCLOPENTOLATE 0.5% EYE DROPS	Gamunex-C 10 gram/100 mL (10 %) injection solution	MILRINONE LACT 50 MG/50 ML VL	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular syringe	Zortress 0.75 mg tablet
CARBOPLATIN 600 MG/60 ML VIAL	Evenity 105 mg/1.17 mL subcutaneous syringe	LEUCOVORIN CALCIUM 100 MG VIAL	Perforomist 20 mcg/2 mL solution for nebulization	Vidaza 100 mg solution for injection
Clinimix 4.25 % in 10 % dextrose Sulfite Free intravenous solution	Firmagon kit with diluent syringe 120 mg subcutaneous solution	LIPODOX 2 MG/ML VIAL	Prevymis 480 mg/24 mL intravenous solution	Xembify 4 gram/20 mL (20 %) subcutaneous solution
Benlysta 400 mg intravenous solution	Emend 80 mg capsule	IPRATROPIUM BR 0.02% SOLN	Ontruzant 150 mg intravenous solution	Triptodur 22.5 mg intramuscular suspension
CLINIMIX E 5%-25% SOLUTION	Folotyn 20 mg/mL (1 mL) intravenous solution	Makena 250 mg/mL intramuscular oil	Prograf 1 mg oral granules in packet	Yervoy 50 mg/10 mL (5 mg/mL) intravenous solution
Aranesp 10 mcg/0.4 mL (in polysorbate) injection syringe	DOCETAXEL 80 MG/4 ML VIAL	HyQvia IG Component 2.5 gram/25 mL (10 %) subcutaneous solution	Nephramine 5.4 % intravenous solution	Synthamin 17 without Electrolyte 10 % intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Adrucil 2.5 gram/50 mL intravenous solution	DACARBAZINE 100 MG VIAL	Granix 480 mcg/0.8 mL subcutaneous syringe	MORPHINE 2 MG/ML ISECURE SYR	Sandimmune 25 mg capsule
ALBUTEROL 100 MG/20 ML SOLN	DAUNORUBICIN 20 MG VIAL	Herceptin 150 mg intravenous solution	MORPHINE 5 MG/ML SYRINGE	Sandostatin LAR Depot 20 mg intramuscular susp,extended release
Boniva 3 mg/3 mL intravenous syringe	Envarsus XR 0.75 mg tablet,extended release	Ixempra 45 mg intravenous solution	OXALIPLATIN 200 MG/40 ML VIAL	TROPICAMIDE 1% EYE DROPS
BUDESONIDE 0.5 MG/2 ML SUSP	EPIRUBICIN HCL 50 MG VIAL	Kanjinti 150 mg intravenous solution	PACLITAXEL 300 MG/50 ML VIAL	Tyvaso Starter Kit 1.74 mg/2.9 mL solution for nebulization
Clinimix 5 % in 25 % dextrose sulfite-free intravenous solution	FLOXURIDINE 500 MG VIAL	Lupron Depot 22.5 mg (3 month) intramuscular syringe kit	PROCHLORPERAZINE 5 MG TABLET	Xerava 50 mg intravenous solution
Belrapzo 25 mg/mL intravenous solution	Elzonris 1,000 mcg/mL intravenous solution	Intron A 10 million unit (1 mL) solution for injection	ONDANSETRON HCL 4 MG TABLET	Trexall 10 mg tablet
AMPHOTERICIN B 50 MG VIAL	DOBUTAMINE 250 MG/250 ML-D5W	HyQvia 20 gram/200 mL (10 %) subcutaneous solution	Naglazyme 5 mg/5 mL intravenous solution	Stelara 130 mg/26 mL intravenous solution
Cimzia Starter Kit 400 mg/2 mL (200 mg/mL x2) subcutaneous syringe kit	FENTANYL 1,000 MCG/20 ML VIAL	LEVALBUTEROL CONC 1.25 MG/0.5	PREDNISONE 1 MG TABLET	Vyepti 100 mg/mL intravenous solution
Aranesp 60 mcg/0.3 mL (in polysorbate) injection syringe	DOXORUBICIN 150 MG/75 ML VIAL	IFOSFAMIDE 3 GM VIAL	Numbrino 4 % nasal solution	THIOTEPA 100 MG VIAL

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Busulfex 60 mg/10 mL intravenous solution	Epogen 20,000 unit/2 mL injection solution	Kedrab (PF) 150 unit/mL intramuscular solution	PALONOSETRON 0.25 MG/2 ML VIAL	Uvadex 20 mcg/mL injection solution
APREPITANT 80 MG CAPSULE	DOCETAXEL 20 MG/2 ML VIAL	HyQvia HY Component 400 unit/2.5 mL subcutaneous solution	Neoral 100 mg capsule	Synagis 50 mg/0.5 mL intramuscular solution
Aliqopa 60 mg intravenous solution	Demerol (PF) 75 mg/mL injection syringe	Hizentra 4 gram/20 mL (20 %) subcutaneous syringe	Mozobil 24 mg/1.2 mL (20 mg/mL) subcutaneous solution	SILDENAFIL 10 MG/12.5 ML VIAL
Arzerra 100 mg/5 mL intravenous solution	DOXORUBICIN LIPOSOME 50MG/25ML	Imlygic 10exp8 (100 million) PFU/mL suspension for injection	OCTREOTIDE 1,000 MCG/5 ML VIAL	TOBRAMYCIN 300 MG/5 ML AMPULE
AZATHIOPRINE SOD 100 MG VIAL	Eligard 45 mg (6 month) subcutaneous syringe	Infugem 2,000 mg/200 mL (10 mg/mL) intravenous piggyback	Ogivri 150 mg intravenous solution	Trelstar 22.5 mg intramuscular suspension
Cuvitru 4 gram/20 mL (20 %) subcutaneous solution	GAMMAKED 2.5 GRAM/25 ML VIAL	METHYLPREDNISOLONE 32 MG TAB	Reblozyl 75 mg subcutaneous solution	ZOLEDRONIC ACID 4 MG/5 ML VIAL
Actemra 80 mg/4 mL (20 mg/mL) intravenous solution	CYCLOSPORINE 25 MG CAPSULE	GEMCITABINE HCL 1 GRAM VIAL	Mitigo (PF) 25 mg/mL injection solution	Retacrit 4,000 unit/mL injection solution
Aminosyn 10 % intravenous solution	DEMEROL 75 MG/1.5 ML AMPUL	HYDROMORPHONE 2 MG/ML VIAL	MYCOPHENOLATE 200 MG/ML SUSP	SIROLIMUS 1 MG/ML SOLUTION
Clolar 20 mg/20 mL intravenous solution	Gablofen 10,000 mcg/20 mL (500 mcg/mL) intrathecal solution	Medrol 8 mg tablet	Pulmicort 1 mg/2 mL suspension for nebulization	Zepzelca 4 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Cerezyme 400 unit intravenous solution	Exondys-51 50 mg/mL intravenous solution	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	Plenamine 15 % intravenous solution	VINCRISTINE 2 MG/2 ML VIAL
Abelcet 5 mg/mL intravenous suspension	CYCLOPHOSPHAMIDE 2 GM VIAL	GANCICLOVIR 500 MG/10 ML VIAL	Mircera 200 mcg/0.3 mL injection syringe	Remodulin 5 mg/mL injection solution
Aminosyn II 7 % intravenous solution	Dilaudid (PF) 0.2 mg/mL injection syringe	HYDROXYPROGEST 1,250 MG/5 ML	Mydriacyl 1 % eye drops	SODIUM CHLORIDE 3% VIAL
Akynzeo (fosnetupitant) 235 mg-0.25 mg intravenous powder for solution	DACTINOMYCIN 0.5 MG VIAL	HepaGam B >312 unit/mL injection solution	MORPHINE 4 MG/ML ISECURE SYR	Sandostatin 50 mcg/mL injection solution
Aminosyn 8.5 % with electrolytes intravenous solution	DEXRAZOXANE 250 MG VIAL	HYDROMORPHONE HCL 1 MG/ML AMP	MYCOPHENOLATE 500 MG VIAL	SMOFlipid 20 % intravenous emulsion
Aranesp 150 mcg/0.3 mL (in polysorbate) injection syringe	DOPAMINE 200 MG-D5W 250 ML	HyQvia IG Component 5 gram/50 mL (10 %) subcutaneous solution	Neupogen 300 mcg/0.5 mL injection syringe	TACROLIMUS 5 MG CAPSULE
CARBOPLATIN 150 MG/15 ML VIAL	ETOPOSIDE 1,000 MG/50 ML VIAL	Lemtrada 12 mg/1.2 mL intravenous solution	Paremyd 1 %-0.25 % eye drops	Ventavis 10 mcg/mL solution for nebulization
Avastin 25 mg/mL intravenous solution	Duramorph (PF) 1 mg/mL injection solution	Infugem 1,200 mg/120 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 100 MCG/ML VL	Torisel 30 mg/3 mL (10 mg/mL) (first dilution) intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CYCLOPENTOLATE HCL 2% DROPS	Gamunex-C 40 gram/400 mL (10 %) injection solution	Mircera 100 mcg/0.3 mL injection syringe	Remodulin 10 mg/mL injection solution	Zuplenz 4 mg oral soluble film
CLINIMIX N14G30E 4.25%-D15W	Foscavir 24 mg/mL intravenous solution	Marinol 5 mg capsule	Prolastin-C 1,000 mg (+/-)/20 mL intravenous solution	Zaltrap 100 mg/4 mL (25 mg/mL) intravenous solution
CLINDAMYCIN 600 MG/50 ML-NS	FENTANYL 500 MCG/10 ML VIAL	Lioresal 2,000 mcg/mL intrathecal solution	Premasol 10 % intravenous solution	Xembify 1 gram/5 mL (20 %) subcutaneous solution
Cyclogyl 1 % eye drops	Gammaplex (with sorbitol) 5 % intravenous solution	Millipred 5 mg tablet	Recombivax HB (PF) 10 mcg/mL intramuscular syringe	ZOMETA 4 MG/5 ML VIAL
Adriamycin 20 mg/10 mL intravenous solution	CYTARABINE 20 MG/ML VIAL	GRANISETRON HCL 1 MG TABLET	MORPHINE 10 MG/ML ISECURE SYRG	Ruxience 10 mg/mL concentrate,intravenous
ALBUTEROL 20 MG/4 ML SOLUTION	DECITABINE 50 MG VIAL	Herzuma 150 mg intravenous solution	MORPHINE 8 MG/ML ISECURE SYRNG	Signifor 0.3 mg/mL (1 mL) subcutaneous solution
CLINIMIX 4.25%-20% SOLUTION	Flebogamma DIF 5 % intravenous solution	Lumoxiti 1 mg intravenous solution	Privigen 10 % intravenous solution	Xeomin 200 unit intramuscular solution
Clinimix 8 % in 14 % dextrose (sulfite-free) intravenous solution	FLUOROURACIL 1,000 MG/20 ML VL	Lupron Depot 7.5 mg intramuscular syringe kit	Procrit 20,000 unit/2 mL injection solution	Xolair 150 mg subcutaneous solution
Botox 200 unit injection	EPIRUBICIN 200 MG/100 ML VIAL	Kadcyla 100 mg intravenous solution	PACLITAXEL 100 MG/16.7 ML VIAL	Tyvaso 1.74 mg/2.9 mL (0.6 mg/mL) solution for nebulization

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
ARSENIC TRIOXIDE 10 MG/10ML VL	DOXORUBICIN 50 MG VIAL	Ilumya 100 mg/mL subcutaneous syringe	Ocrevus 30 mg/mL intravenous solution	Tigan 300 mg capsule
CHLORPROMAZINE 25 MG TABLET	Fasenra 30 mg/mL subcutaneous syringe	LEVALBUTEROL 0.31 MG/3 ML SOL	Portrazza 800 mg/50 mL (16 mg/mL) intravenous solution	Virazole 6 gram solution for inhalation
Cuvitru 1 gram/5 mL (20 %) subcutaneous solution	Gammagard S-D (IgA < 1 mcg/mL) 5 gram intravenous solution	Mesnex 100 mg/mL intravenous solution	Rayos 2 mg tablet,delayed release	Zoladex 3.6 mg subcutaneous implant
Benlysta 120 mg intravenous solution	Emend 125 mg (25 mg/mL final conc.) oral suspension	Intron A 50 million unit (1 mL) solution for injection	ONDANSETRON ODT 8 MG TABLET	Trexall 7.5 mg tablet
ACYCLOVIR 500 MG/10 ML VIAL	CYCLOSPORINE MODIFIED 100MG/ML	GEMZAR 1 GRAM VIAL	MITOMYCIN 5 MG VIAL	Revatio 10 mg/12.5 mL intravenous solution
CALCIUM GLUC 5,000 MG/50 ML VL	Epogen 4,000 unit/mL injection solution	Khapzory 300 mg intravenous solution	PAMIDRONATE 30 MG/10 ML VIAL	Varizig 125 unit/1.2 mL intramuscular solution
APREPITANT 125 MG CAPSULE	Docefrez 80 mg intravenous solution	HyQvia HY Component 1,600 unit/10 mL subcutaneous solution	Nebupent 300 mg solution for inhalation	Sylvant 100 mg intravenous solution
Compazine 5 mg tablet	Gablofen 20,000 mcg/20 mL (1,000 mcg/mL) intrathecal syringe	MELPHALAN HCL 50 MG VIAL	Quzyttir 10 mg/mL intravenous solution	ZINECARD 250 MG VIAL
Aloxi 0.25 mg/5 mL intravenous solution	DEMEROL 25 MG/0.5 ML AMPUL	HYDROMORPHONE 1 MG/ML CARPUJCT	Mutamycin 40 mg intravenous solution	Simulect 20 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Astagraf XL 1 mg capsule,extended release	DRONABINOL 5 MG CAPSULE	Imuran 50 mg tablet	OCTREOTIDE ACET 0.05 MG/ML VL	TOPOTECAN HCL 1 MG/ML VIAL
BACLOFEN 40 MG/20 ML VIAL	Elitek 7.5 mg intravenous solution	Infumorph P/F 25 mg/mL injection solution	Oncaspar 750 unit/mL injection solution	TREPROSTINIL 20 MG/20 ML VIAL
ACETYLCYSTEINE 20% VIAL	CYCLOPHOSPHAMIDE 500 MG VIAL	GEMCITABINE 1 GRAM/26.3 ML VL	Mircera 75 mcg/0.3 mL injection syringe	Retacrit 2,000 unit/mL injection solution
CellCept 250 mg capsule	EVEROLIMUS 0.5 MG TABLET	LEUCOVORIN CALCIUM 50 MG VIAL	Phesgo 1,200 mg-600 mg-30,000 unit/15 mL subcutaneous solution	Vincasar PFS 1 mg/mL intravenous solution
BLEOMYCIN SULFATE 15 UNIT VIAL	Enhertu 100 mg intravenous solution	Istodax 10 mg/2 mL intravenous solution	OXALIPLATIN 100 MG VIAL	TROPICAMIDE 0.5% EYE DROPS
Avycaz 2.5 gram intravenous solution	Dysport 500 unit intramuscular solution	Infugem 1,500 mg/150 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 50 MCG/ML SYR	Travasol 10 % intravenous solution
CLINDAMYCIN 900 MG/50 ML-NS	Fetroja 1 gram intravenous solution	Lioresal 50 mcg/mL intrathecal solution	PREMASOL 6% IV SOLUTION	Xembify 10 gram/50 mL (20 %) subcutaneous solution
CARBOPLATIN 450 MG/45 ML VIAL	ETOPOSIDE 100 MG/5 ML VIAL	LEUCOVORIN CAL 100 MG/10 ML VL	Parsabiv 5 mg/mL intravenous solution	Ventavis 20 mcg/mL solution for nebulization
Cyclogyl 2 % eye drops	Gammaplex 10 % intravenous solution	MILRINONE LACT 10 MG/10 ML VL	Recombivax HB (PF) 40 mcg/mL intramuscular suspension	Zortress 0.25 mg tablet

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CLINIMIX N9G15E 2.75%-D7.5W	FREAMINE HBC 6.9% IV SOLN	Marqibo 5 mg/31 mL (0.16 mg/mL) (Final Conc.) intravenous kit	Prolastin-C 1,000 mg intravenous powder for solution	Zaltrap 200 mg/8 mL (25 mg/mL) intravenous solution
Brovana 15 mcg/2 mL solution for nebulization	EPIRUBICIN 50 MG/25 ML VIAL	Kadcyla 160 mg intravenous solution	PACLITAXEL 150 MG/25 ML VIAL	Tyvaso Institutional Starter Kit 1.74 mg/2.9 mL soln for nebulization
Aralast NP 1,000 mg intravenous solution	DOCETAXEL 20 MG/ML VIAL	HyQvia HY Component 800 unit/5 mL subcutaneous solution	Neoral 100 mg/mL oral solution	Syndros 5 mg/mL oral solution
Aranesp 40 mcg/mL (in polysorbate) Injection	DOXORUBICIN 10 MG VIAL	IFOSFAMIDE 1 GM VIAL	Nucala 100 mg subcutaneous solution	Tepadina 15 mg solution for injection
Adriamycin 50 mg intravenous solution	CytoGam 50 mg/mL intravenous solution	Granix 300 mcg/0.5 mL subcutaneous syringe	MORPHINE 10 MG/ML SYRINGE	Sandimmune 100 mg capsule
Aranesp 200 mcg/mL (in polysorbate) Injection	DOPAMINE 400 MG/10 ML VIAL	Idamycin PFS 1 mg/mL intravenous solution	Neupogen 480 mcg/1.6 mL injection solution	Tecentriq 1,200 mg/20 mL (60 mg/mL) intravenous solution
Clinimix 5 % in 15 % dextrose Sulfite Free intravenous solution	Flolan 0.5 mg intravenous solution	Lupron Depot (6 Month) 45 mg intramuscular syringe kit	Procalamine 3% intravenous solution	Xeomin 50 unit intramuscular solution
Akynzeo (fosnetupitant) 235 mg-0.25 mg/20 mL intravenous solution	Darzalex 20 mg/mL intravenous solution	HepaGam B greater than 312 unit/mL 5 mL injection solution	MORPHINE 4 MG/ML SYRINGE	Sandostatin 500 mcg/mL injection solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Alimta 100 mg intravenous solution	Demerol (PF) 25 mg/mL injection syringe	Hizentra 2 gram/10 mL (20 %) subcutaneous syringe	MORPHINE SULFATE 5 MG/ML VIAL	Signifor LAR 40 mg intramuscular suspension
Bavencio 20 mg/mL intravenous solution	Ellence 200 mg/100 mL intravenous solution	Intralipid 20 % intravenous emulsion	ONDANSETRON 4 MG/5 ML SOLUTION	TREPROSTINIL 200 MG/20 ML VIAL
Clinimix E 4.25 % in 10 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 2.5 GM/50 ML VIAL	Lupron Depot-Ped 15 mg intramuscular kit	Procrit 4,000 unit/mL injection solution	Xopenex 0.31 mg/3 mL solution for nebulization
Cuvitru 10 gram/50 mL (20 %) subcutaneous solution	Gammaked 1 gram/10 mL (10 %) injection solution	METHOTREXATE 2.5 MG TABLET	Rayos 5 mg tablet,delayed release	ZOLEDRONIC ACID 4 MG VIAL
ARSENIC TRIOXIDE 12 MG/6 ML VL	DOXORUBICIN 50 MG/25 ML VIAL	Imfinzi 50 mg/mL intravenous solution	Octagam 10 % intravenous solution	Tobi 300 mg/5 mL solution for nebulization
Adakveo 10 mg/mL intravenous solution	Cyklokapron 1,000 mg/10 mL (100 mg/mL) intravenous solution	Gengraf 100 mg/mL oral solution	MITOXANTRONE 30 MG/15 ML VIAL	Rituxan Hycela 1,400 mg/11.7 mL (120 mg/mL) subcutaneous solution
APREPITANT 125-80-80 MG PACK	DOCETAXEL 160 MG/16 ML VIAL	HyQvia HY Component 2,400 unit/15 mL subcutaneous solution	NebuSal 3 % solution for nebulization	Sylvant 400 mg intravenous solution
Caldolor 800 mg/8 mL (100 mg/mL) intravenous solution	Erbitux 100 mg/50 mL intravenous solution	Kyprolis 10 mg intravenous solution	PAMIDRONATE DISOD 30 MG VIAL	Vectibix 100 mg/5 mL (20 mg/mL) intravenous solution
AmBisome 50 mg intravenous suspension	DEMEROL 50 MG/ML AMPUL	HYDROMORPHONE 1 MG/ML SYRINGE	Mutamycin 5 mg intravenous solution	SIROLIMUS 0.5 MG TABLET

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Actemra 200 mg/10 mL (20 mg/mL) intravenous solution	CYCLOPHOSPHAMIDE 500 MG/2.5 ML	GEMCITABINE 2 GRAM/52.6 ML VL	Mirena 20 mcg/24 hours (6 yrs) 52 mg intrauterine device	Retacrit 20,000 unit/2 mL injection solution
Aminosyn-PF 7 % (sulfite-free) intravenous solution	DOBUTAMINE 12.5 MG/ML VIAL	HyQvia 10 gram/100 mL (10 %) subcutaneous solution	Myobloc 5,000 unit/mL intramuscular solution	Spravato 56 mg (28 mg x 2) nasal spray
Crysvita 10 mg/mL subcutaneous solution	Gablofen 50 mcg/mL (1 mL) intrathecal syringe	MEPERIDINE 25 MG/ML VIAL	Rapamune 0.5 mg tablet	Zirabev 25 mg/mL intravenous solution
Azasan 75 mg tablet	Eligard 22.5 mg (3 month) subcutaneous syringe	Infugem 1,800 mg/180 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 500 MCG/ML SYR	Treanda 25 mg intravenous powder for solution
CellCept 500 mg tablet	EVEROLIMUS 0.75 MG TABLET	LEUCOVORIN CALCIUM 500 MG VL	Phesgo 600 mg-600 mg-20,000 unit/10 mL subcutaneous solution	Vincasar PFS 2 mg/2 mL intravenous solution
Clinimix 4.25 % in 25 % dextrose (sulfite-free) intravenous solution	Firmagon kit with diluent syringe 80 mg subcutaneous solution	LIPODOX 50 2 MG/ML VIAL	Prialt 100 mcg/mL intrathecal solution	Xenleta 150 mg/15 mL intravenous solution
Clinolipid 20 % intravenous emulsion	FULVESTRANT 250 MG/5 ML SYRING	Medrol 32 mg tablet	Pulmicort 0.25 mg/2 mL suspension for nebulization	Zarxio 480 mcg/0.8 mL injection syringe
BiCNU 100 mg intravenous solution	Engerix-B (PF) 20 mcg/mL intramuscular suspension	IRINOTECAN HCL 40 MG/2 ML VIAL	Opdivo 240 mg/24 mL intravenous solution	TrophAmine 10 % intravenous solution
Camptosar 40 mg/2 mL intravenous solution	Ethyol 500 mg intravenous solution	LARTRUVO 190 MG/19 ML VIAL	ParaGard T 380A 380 square mm intrauterine device	Veletri 0.5 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CLADRIBINE 10 MG/10 ML VIAL	FENTANYL 250 MCG/5 ML VIAL	LIDOCAINE-PRILOCAINE CREAM	PREDNISONE 50 MG TABLET	WinRho SDF 5,000 unit (1,000 mcg)/4.4 mL injection solution
Clinimix E 8 % in 10 % dextrose (sulfite-free) intravenous solution	Folotyn 40 mg/2 mL (20 mg/mL) intravenous solution	Marinol 10 mg capsule	Prograf 5 mg capsule	Yondelis 1 mg intravenous solution
BORTEZOMIB 3.5 MG VIAL	Envarsus XR 1 mg tablet,extended release	Jevtana 10 mg/mL (first dilution) intravenous solution	OXALIPLATIN 50 MG VIAL	Truxima 10 mg/mL concentrate,intravenous
BUDESONIDE 1 MG/2 ML INH SUSP	Epogen 10,000 unit/mL injection solution	Kanjinti 420 mg intravenous solution	Padcev 20 mg intravenous solution	Udenyca 6 mg/0.6 mL subcutaneous syringe
ADRUCIL 5 GRAM/100 ML VIAL	DACARBAZINE 200 MG VIAL	Granix 480 mcg/1.6 mL subcutaneous solution	MORPHINE 2 MG/ML SYRINGE	Sandimmune 250 mg/5 mL intravenous solution
Aranesp 300 mcg/0.6 mL (in polysorbate) injection syringe	DOPAMINE 800 MG/250 ML-D5W BAG	IDARUBICIN HCL 5 MG/5 ML VIAL	Nivestym 300 mcg/mL injection solution	TEMSIROLIMUS 25 MG VIAL
Curosurf 120 mg/1.5 mL intratracheal suspension	Gammagard Liquid 10 % injection solution	MESNA 1 GRAM/10 ML VIAL	Rapamune 2 mg tablet	ZOFRAN 8 MG TABLET
ANZEMET 100 MG TABLET	DOBUTAMINE 500 MG/250 ML D5W	HyQvia 30 gram/300 mL (10 %) subcutaneous solution	Navelbine 10 mg/mL intravenous solution	Survanta 25 mg/mL intratracheal suspension
BENDAMUSTINE 100 MG/4 ML VIAL	Emend (fosaprepitant) 150 mg intravenous solution	Intron A 10 million unit/mL injection solution	ONDANSETRON HCL 8 MG TABLET	Trexall 15 mg tablet

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Aranesp 60 mcg/mL (in polysorbate) Injection	DOXORUBICIN 20 MG/10 ML VIAL	IFOSFAMIDE 3 GM/60 ML VIAL	Nutrilipid 20 % intravenous emulsion	THIOTEPA 15 MG VIAL
ALBUTEROL SUL 1.25 MG/3 ML SOL	Defitelio 80 mg/mL intravenous solution	Hizentra 1 gram/5 mL (20 %) subcutaneous syringe	MORPHINE SULFATE 10 MG/ML VIAL	Signifor LAR 10 mg intramuscular suspension
Alkeran (as HCl) 50 mg intravenous solution	DEMEROL 100 MG/ML AMPUL	Hycamtin 4 mg intravenous solution	MUSTARGEN 10 MG VIAL	Simponi ARIA 12.5 mg/mL intravenous solution
Adriamycin 10 mg/5 mL intravenous solution	CYTARABINE 1000 MG/50 ML VIAL	Glassia 1 gram/50 mL (2 %) intravenous solution	MORPHINE 10 MG/10 ML VIAL	ROMIDEPSIN 10 MG VIAL
Clinimix E 5 % in 15 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 5,000 MG/100 ML	Makena (PF) 275 mg/1.1 mL subcutaneous auto-injector	Prograf 0.5 mg capsule	Xopenex Concentrate 1.25 mg/0.5 mL solution for nebulization
Asceniv 10 % intravenous solution	DRONABINOL 10 MG CAPSULE	Imogam Rabies-HT (PF) 150 unit/mL intramuscular solution	OCTREOTIDE 1,000 MCG/ML VIAL	TOBRAMYCIN PAK 300 MG/5 ML
CISPLATIN 100 MG/100 ML VIAL	FENTANYL 100 MCG/2 ML VIAL	LEVOLEUCOVORIN 250 MG/25 ML VL	PREDNISONE 20 MG TABLET	WinRho SDF 1,500 unit (300 mcg)/1.3 mL injection solution
Cuvitru 8 gram/40 mL (20 %) subcutaneous solution	Gammaked 20 gram/200 mL (10 %) injection solution	METHYLPREDNISOLONE 4 MG TABLET	Reclast 5 mg/100 mL intravenous piggyback	ZOLEDRONIC ACID 5 MG/100 ML
Aminosyn M 3.5 % intravenous solution	Dilaudid (PF) 2 mg/mL injection syringe	HyperRAB (PF) 300 unit/mL intramuscular solution	Mylotarg 4.5 mg (1 mg/mL initial concentration) intravenous solution	Somatuline Depot 90 mg/0.3 mL subcutaneous syringe

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
BACLOFEN 10 MG/20 ML VIAL	Eligard 7.5 mg (1 month) subcutaneous syringe	Infugem 2,200 mg/220 mL (10 mg/mL) intravenous piggyback	Ogivri 420 mg intravenous solution	Trelstar 3.75 mg intramuscular suspension
Aminosyn 7 % with electrolytes intravenous solution	Desferal 2 gram solution for injection	HYDROMORPHONE 4 MG/ML CARPUJCT	MYCOPHENOLATE 250 MG CAPSULE	SIROLIMUS 2 MG TABLET
CARMUSTINE 100 MG VIAL	Evenity 210 mg/2.34 mL (105 mg/1.17 mL x 2) subcutaneous syringe	LEUCOVORIN CALCIUM 200 MG VIAL	Perikabiven 2.36 %-6.8 %-3.5 % intravenous emulsion	Viltepso 50 mg/mL intravenous solution
Abraxane 100 mg intravenous suspension	CYCLOPHOSPHAMIDE 25 MG CAPSULE	GANCICLOVIR 500 MG/250 ML BAG	Mircera 30 mcg/0.3 mL injection syringe	Renflexis 100 mg intravenous solution
Aminosyn II 10 % intravenous solution	DEXRAZOXANE 500 MG VIAL	HYDROMORPHONE HCL 2 MG/ML AMP	MYCOPHENOLIC ACID DR 180 MG TB	SODIUM CHLORIDE 0.9% INHAL VL
Aranesp 150 mcg/0.75 mL (in polysorbate) Injection	DOPAMINE 200 MG/5 ML VIAL	IBANDRONATE 3 MG/3 ML SYRINGE	Neupogen 300 mcg/mL injection solution	Taxotere 20 mg/mL (1 mL) intravenous solution
Aveed 750 mg/3 mL (250mg/mL) intramuscular solution	Durysta 10 mcg intracameral implant	Infugem 1,300 mg/130 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 200 MCG/ML VL	Totect 500 mg intravenous solution
Bivigam 10 % intravenous solution	Engerix-B (PF) 20 mcg/mL intramuscular syringe	IRINOTECAN HCL 500 MG/25 ML VL	Opdivo 40 mg/4 mL intravenous solution	TROPHAMINE 6% IV SOLUTION
CARBOPLATIN 150 MG VIAL	Etopophos 100 mg intravenous solution	LARTRUVO 500 MG/50 ML VIAL	Paraplatin 10 mg/mL intravenous solution	Veletri 1.5 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CLINDAMYCIN 300 MG/50 ML-NS	FENTANYL 50 MCG/ML VIAL	Liletta 20.1 mcg/24 hrs (6 yrs) 52 mg intrauterine device	Prednisone Intensol 5 mg/mL oral concentrate	Xatmep 2.5 mg/mL oral solution
Clinimix E 8 % in 14 % dextrose (sulfite-free) intravenous solution	FOSAPREPITANT 150 MG VIAL	Marinol 2.5 mg capsule	Prograf 5 mg/mL intravenous solution	Yupelri 175 mcg/3 mL solution for nebulization
Aranesp 300 mcg/mL (in polysorbate) Injection	DOPAMINE 800 MG/500 ML-D5W BAG	Ifex 1 gram intravenous solution	Nivestym 480 mcg/0.8 mL subcutaneous syringe	TENIPOSIDE 50 MG/5 ML AMPULE
Adriamycin 2 mg/mL intravenous solution	CYTARABINE 2 G/20 ML VIAL	Goprelto 4 % nasal solution	MORPHINE 10 MG/ML CARPUJECT	ROMIDEPSIN 27.5 MG/5.5 ML VIAL
ALBUTEROL 5 MG/ML SOLUTION	DEFEROXAMINE 2 GRAM VIAL	Herzuma 420 mg intravenous solution	MORPHINE 8 MG/ML SYRINGE	Signifor 0.6 mg/mL (1 mL) subcutaneous solution
CYCLOPHOSPHAMIDE 1 GM VIAL	Gamunex-C 5 gram/50 mL (10 %) injection solution	Mircera 150 mcg/0.3 mL injection syringe	Remodulin 2.5 mg/mL injection solution	Zuplenz 8 mg oral soluble film
Botox 100 unit injection	Envarsus XR 4 mg tablet,extended release	Kabiven 3.31 %-9.8 %-3.9 % intravenous emulsion	OXALIPLATIN 50 MG/10 ML VIAL	Tysabri 300 mg/15 mL intravenous solution
ANZEMET 50 MG TABLET	Docefrez 20 mg intravenous solution	HyQvia 5 gram/50 mL (10 %) subcutaneous solution	Navelbine 50 mg/5 mL intravenous solution	Sustol 10 mg/0.4 mL liquid,extended release subcutaneous syringe
Arestin 1 mg dental cartridge	DOXORUBICIN 200 MG/100 ML VIAL	IFOSFAMIDE-MESNA KIT	Nuzyra 100 mg intravenous solution	Thymoglobulin 25 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Clinimix E 2.75 % in 5 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 2,500 MG/50 ML VL	Lupron Depot-Ped 11.25 mg (3 month) intramuscular syringe kit	Procrit 20,000 unit/mL injection solution	Xolair 150 mg/mL subcutaneous syringe
Cimzia 400 mg/2 mL (200 mg/mL x 2) subcutaneous syringe kit	Faslodex 250 mg/5 mL intramuscular syringe	LEVALBUTEROL 0.63 MG/3 ML SOL	POTASSIUM PHOSPH 45 MMOL/15 ML	VORICONAZOLE 200 MG VIAL
Cutaquig 16.5 % subcutaneous solution	Gammagard S-D (IgA < 1 mcg/mL) 10 gram intravenous solution	MESNA 100 MG/ML VIAL	Rayos 1 mg tablet,delayed release	Zoladex 10.8 mg subcutaneous implant
CALCIUM GLUCONATE 10% VIAL	EPOPROSTENOL SODIUM 0.5 MG VL	Kitabis Pak 300 mg/5 mL solution for nebulization	PAMIDRONATE 60 MG/10 ML VIAL	Varubi 166.5 mg/92.5 mL intravenous emulsion
ALBUTEROL SUL 2.5 MG/3 ML SOLN	Demerol (PF) 100 mg/2 mL injection solution	Hizentra 10 gram/50 mL (20 %) subcutaneous solution	MORPHINE SULFATE 2 MG/ML VIAL	Signifor LAR 20 mg intramuscular suspension
Alkeran 2 mg tablet	Demerol 100 mg/mL injection solution	HYDROMORPHONE 0.5 MG/0.5 ML	Mutamycin 20 mg intravenous solution	Simulect 10 mg intravenous solution
ACYCLOVIR SODIUM 1 GM VIAL	CYCLOSPORINE MODIFIED 25 MG	GEMZAR 200 MG VIAL	MITOXANTRONE 20 MG/10 ML VIAL	RIBAVIRIN 6 GM INHALATION VIAL
Clinimix E 5 % in 20 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 500 MG/10 ML VIAL	Makena 250 mg/mL (1 mL) intramuscular oil	Prograf 1 mg capsule	Yervoy 200 mg/40 mL (5 mg/mL) intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Benlysta 200 mg/mL subcutaneous auto-injector	EMEND 125 MG CAPSULE	Intron A 6 million unit/mL injection solution	Onivyde 4.3 mg/mL intravenous dispersion	Triesence (PF) 40 mg/mL intraocular suspension
CISPLATIN 200 MG/200 ML VIAL	FENTANYL 2,500 MCG/50 ML VIAL	LEVOLEUCOVORIN 50 MG VIAL	PREDNISONE 5 MG TABLET	WinRho SDF 15,000 unit (3,000 mcg)/13 mL injection solution
Aminosyn-HBC 7% intravenous solution	Dilaudid (PF) 4 mg/mL injection syringe	HyperRAB S/D (PF) 150 unit/mL intramuscular solution	Myobloc 10,000 unit/2 mL intramuscular solution	Spinraza (PF) 12 mg/5 mL intrathecal solution
Astagraf XL 5 mg capsule,extended release	Duopa 4.63 mg-20 mg/mL suspension in j-tube pump	Infed 50 mg/mL injection solution	OCTREOTIDE ACET 100 MCG/ML AMP	TOPOTECAN HCL 4 MG VIAL
BACLOFEN 20,000 MCG/20 ML VIAL	Elitek 1.5 mg intravenous solution	Infumorph P/F 10 mg/mL injection solution	Omegaven 10 % intravenous emulsion	TREPROSTINIL 100 MG/20 ML VIAL
AZACITIDINE 100 MG VIAL	Elaprase 6 mg/3 mL intravenous solution	Infugem 1,600 mg/160 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 50 MCG/ML VIAL	Trazimera 420 mg intravenous solution
Cosmegen 0.5 mg intravenous solution	Gablofen 40,000 mcg/20 mL (2,000 mcg/mL) intrathecal solution	MEPERIDINE 10 MG/ML CARTRDGE	RabAvert (PF) 2.5 unit intramuscular suspension	ZINECARD 500 MG VIAL
CARBOPLATIN 50 MG/5 ML VIAL	ETOPOSIDE 500 MG/25 ML VIAL	LEUCOVORIN CAL 500 MG/50 ML VL	PENTAMIDINE 300 MG INHAL POWDR	Vfend IV 200 mg intravenous solution
CYCLOPENTOLATE 1% EYE DROP	Gamunex-C 2.5 gram/25 mL (10 %) injection solution	MILRINONE-D5W 20 MG/100 ML	Remicade 100 mg intravenous solution	Zortress 1 mg tablet

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
BLEOMYCIN SULFATE 30 UNIT VIAL	Entyvio 300 mg intravenous solution	Ixempra 15 mg intravenous solution	OXALIPLATIN 100 MG/20 ML VIAL	TROPICAMIDE 1% EYE DROP
CLINIMIX 2.75%-5% SOLUTION	Firmagon 120 mg subcutaneous solution	Lioresal 500 mcg/mL intrathecal solution	Prevymis 240 mg/12 mL intravenous solution	Xembify 2 gram/10 mL (20 %) subcutaneous solution
Besponsa 0.9 mg(0.25 mg/mL initial concentration) intravenous solution	Empliciti 300 mg intravenous solution	IRINOTECAN HCL 100 MG/5 ML VL	Ontruzant 420 mg intravenous solution	Trisenox 2 mg/mL intravenous solution
Adriamycin 50 mg/25 mL intravenous solution	Cytovene 500 mg intravenous solution	Granix 300 mcg/mL subcutaneous solution	MORPHINE 2 MG/ML CARPUJECT	Sandimmune 100 mg/mL oral solution
Aranesp 100 mcg/0.5 mL (in polysorbate) injection syringe	DOCETAXEL 80 MG/8 ML VIAL	HyQvia IG Component 20 gram/200 mL (10 %) subcutaneous solution	Neulasta 6 mg/0.6 mL subcutaneous syringe	TACROLIMUS 0.5 MG CAPSULE
Aranesp 500 mcg/mL (in polysorbate) injection syringe	DOXORUBICIN 10 MG/5 ML VIAL	IFOSFAMIDE 1 GM/20 ML VIAL	Nulojix 250 mg intravenous solution	Tepezza 500 mg intravenous solution
ALBUTEROL 15 MG/3 ML SOLUTION	DAUNORUBICIN 20 MG/4 ML VIAL	HERCEPTIN 440 MG VIAL	MORPHINE 5 MG/ML VIAL	Sandostatin LAR Depot 30 mg intramuscular susp,extended release
Clinimix 6 % in 5 % dextrose (sulfite-free) intravenous solution	FLUDARABINE 50 MG VIAL	Lupron Depot 3.75 mg intramuscular syringe kit	Procrit 10,000 unit/mL injection solution	Xgeva 120 mg/1.7 mL (70 mg/mL) subcutaneous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Aranesp 25 mcg/0.42 mL (in polysorbate) injection syringe	DOPAMINE 400 MG/250 ML-D5W BAG	IDARUBICIN HCL 10 MG/10 ML VL	Nipent 10 mg intravenous solution	Tecentriq 840 mg/14 mL (60 mg/mL) intravenous solution
CALCIUM GLUC 1,000 MG/10 ML VL	Epogen 20,000 unit/mL injection solution	Keytruda 25 mg/mL intravenous solution	PALONOSETRON 0.25 MG/5 ML VIAL	VALRUBICIN 200 MG/5 ML VIAL
Clinimix E 4.25 % in 5 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 5 GM/100 ML BTL	Lupron Depot-Ped 30 mg (3 month) intramuscular syringe kit	Procrit 40,000 unit/mL injection solution	Xopenex 0.63 mg/3 mL solution for nebulization
Aminosyn-RF 5.2 % intravenous solution	DOBUTAMINE 250 MG/20 ML VIAL	HyQvia 2.5 gram/25 mL (10 %) subcutaneous solution	Myxredlin 100 unit/100 mL (1 unit/mL) intravenous solution	Spravato 84 mg (28 mg x 3) nasal spray
Cinqair 10 mg/mL intravenous solution	FENTANYL 100 MCG/2 ML AMPUL	LEVOLEUCOVORIN 175 MG VIAL	PREDNISONE 10 MG TABLET	Vyondys-53 50 mg/mL intravenous solution
Cuvitru 2 gram/10 mL (20 %) subcutaneous solution	Gammaked 10 gram/100 mL (10 %) injection solution	METHYLPREDNISOLONE 16 MG TAB	Reblozyl 25 mg subcutaneous solution	ZOLEDRONIC ACID 4 MG/100 ML
Adcetris 50 mg intravenous solution	Cyramza 10 mg/mL intravenous solution	Gengraf 25 mg capsule	Monjuvi 200 mg intravenous solution	Rituxan Hycela 1,600 mg/13.4 mL (120 mg/mL) subcutaneous solution
Alimta 500 mg intravenous solution	Demerol (PF) 50 mg/mL injection syringe	Hizentra 4 gram/20 mL (20 %) subcutaneous solution	MORPHINE SULFATE 8 MG/ML VIAL	Signifor LAR 60 mg intramuscular suspension
Camptosar 100 mg/5 mL intravenous solution	Erbitux 200 mg/100 mL intravenous solution	Kyprolis 30 mg intravenous solution	PAMIDRONATE DISOD 90 MG VIAL	Vectibix 400 mg/20 mL (20 mg/mL) intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Acthar 80 unit/mL injection gel	CYCLOSPORINE 250 MG/5 ML AMPUL	GEMCITABINE HCL 2 GRAM VIAL	MITOMYCIN 20 MG VIAL	Retacrit 40,000 unit/mL injection solution
Aminosyn II 8.5 % intravenous solution	Dilaudid (PF) 0.5 mg/0.5 mL injection syringe	HYDROXYPROGEST 250 MG/ML VIAL	Myfortic 180 mg tablet,delayed release	Somatuline Depot 120 mg/0.5 mL subcutaneous syringe
Cesamet 1 mg capsule	Fabrazyme 35 mg intravenous solution	LEUPROLIDE 2WK 14 MG/2.8 ML KT	Polivy 140 mg intravenous solution	VINORELBINE 10 MG/ML VIAL
COCAINE HCL 4% NASAL SOLUTION	Gablofen 10,000 mcg/20 mL (500 mcg/mL) intrathecal syringe	MELPHALAN 2 MG TABLET	Pulmozyme 1 mg/mL solution for inhalation	Ziextenzo 6 mg/0.6 mL subcutaneous syringe
Crysvita 20 mg/mL subcutaneous solution	Gamastan 15 %-18 % range intramuscular solution	MEPERIDINE 50 MG/ML VIAL	Rapamune 1 mg tablet	Zofran 4 mg tablet
AZATHIOPRINE 50 MG TABLET	Eligard 30 mg (4 month) subcutaneous syringe	Infugem 1,900 mg/190 mL (10 mg/mL) intravenous piggyback	OCTREOTIDE ACET 500 MCG/ML VL	Trelstar 11.25 mg intramuscular suspension

IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Member Services Department. 11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call **1-800-794-5907 (TTY: 711)**. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
ગુજરાતી (Gujarati): નઃશૂલ્ક ભાષા સહાય સેવાઓ પ્રાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કૉલ કરો.
ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad beeáká'ánída'áwo'dęę nika'adoowoł.
العربية (Arabic): الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك