ACROMEGALY

Drugs
PEGVISOMANT 10 MG INJECTION [SOMAVERT], PEGVISOMANT 15 MG INJECTION [SOMAVERT], PEGVISOMANT 20 MG INJECTION [SOMAVERT], SOMATULINE DEPOT

Covered Uses
* Acromegaly

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had surgical resection of the pituitary gland OR is not a candidate for surgery/radiation therapy,
2. Patient has tried at least ONE of the following:
   a. Bromocriptine, b. Cabergoline, c. Octreotide

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, Oncologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ACTEMRA

Drugs
ACTEMRA, ACTEMRA ACTPEN

Covered Uses
* Cytokine Release Syndrome
* Giant Cell Arteritis (GCA)
* Juvenile Idiopathic Arthritis (JIA)
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. For RA, JIA dx:
   a. Pt has previous trial on at least TWO of the following:
      Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
ACTIMMUNE

Drugs
ACTIMMUNE

Covered Uses
* Chronic Granulomatous Disease

Exclusion Criteria
1. Hypersensitivity to Actimmune or E. coli derived products

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ADEMPAS

Drugs
ADEMPAS

Covered Uses
* Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
* Pulmonary Arterial Hypertension (PAH)

Exclusion Criteria
N/A

Required Medical Information
1. PAH:
   a. Pt has previous failure on sildenafil,
2. CTPH:
   a. Pt has failed endarterectomy OR
   b. Pt considered inoperable for pulmonary endarterectomy AND
   c. Pt has previous trial on full anticoagulation for at least 90 days

Age Restrictions
18 years old or older

Prescriber Restrictions
Specialist in pulmonary hypertension

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
AIMOVIG

Drugs
AIMOVIG

Covered Uses
* Migraine

Exclusion Criteria
1. Pt has received botulinum injections for migraine prophylaxis in the past 3 months,
2. Aimovig will be used in combination with botulinum toxin migraine prophylaxis therapy

Required Medical Information
1. Initial:
   a. Pt experiences greater than or equal to 4 migraine days per month,
   b. Pt has trial on prophylactic therapy on at least TWO of the following:
      i. Anti-epileptic drug,
      ii. Beta-blocker,
      iii. Antidepressant
2. Reauth:
   a. Pt has had a reduction in migraine days of at least 2 per month

Age Restrictions
N/A

Prescriber Restrictions
Neurologist, Headache Specialist

Coverage Duration
Initial: 3 Months
Reauth: Plan Year

Updated 2/28/2020
Other Criteria
N/A
AJOVY

Drugs
AJOVY

Covered Uses
* Migraine

Exclusion Criteria
1. Pt has received botulinum injections for migraine prophylaxis in the past 3 months,
2. Aimovig will be used in combination with botulinum toxin migraine prophylaxis therapy

Required Medical Information
1. Initial:
   a. Pt experiences greater than or equal to 4 migraine days per month,
   b. Pt has trial on prophylactic therapy on at least TWO of the following:
      i. Anti-epileptic drug,
      ii. Beta-blocker,
      iii. Antidepressant
2. Reauth:
   a. Pt has had a reduction in migraine days of at least 2 per month

Age Restrictions
N/A

Prescriber Restrictions
Neurologist, Headache Specialist

Coverage Duration
Initial: 6 Months
Reauth: Plan Year

Updated 2/28/2020
Other Criteria
N/A
ALBENZA

Drugs
ALBENDAZOLE

Covered Uses
* Hydatid Disease
* Neurocysticerocosis

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A
ALECENSA

Drugs
ALECENSA, ALUNBRIG

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous failure on Xalkori

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
AMPHOB

Drugs
AMPHOTERICIN B, AMPHOTERICIN B LIPOSOMAL 50 MG INJECTION [AMBISOME]

Covered Uses
* Aspergillosis
* Candidiasis
* Coccidioidomycosis
* Cryptococcosis (Torulosis)
* Histoplasmosis
* Infection caused by related susceptible species of Conidiobolus, Basidiobolos, and Sporotrichosis
* North American Blastomycosis

Exclusion Criteria
N/A

Required Medical Information
1. For use of brand Ambisome:
   a. Pt must have previous failure or contraindication to generic Amphotericin B,
2. If using for empiric therapy:
   a. Patient must be febrile AND neutropenic

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
BvsD determination
AMPYRA

Drugs
12 HR DALFAMPRIDINE 10 MG EXTENDED RELEASE ORAL TABLET

Covered Uses
* Multiple Sclerosis (MS)

Exclusion Criteria
1. Pt confined to wheelchair,
2. Hx of seizures,
3. Moderate to severe renal impairment (CrCl is less than 50 mL/min)

Required Medical Information
1. Initial:
   a. Currently taking at least one other MS drug,
   b. Documented 25 foot walk time,
2. Reauth:
   a. Currently taking at least one other MS drug,
   b. Improvement in 25 foot walk time

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Initial: 3 mo,
Reauth: Plan Year

Other Criteria
N/A
Updated 2/28/2020
ANDROGENS

Drugs
120 ACTUAT TESTOSTERONE 10 MG/ACTUAT TOPICAL GEL, 24 HR TESTOSTERONE 0.0833 MG/HR TRANSDERMAL SYSTEM [ANDRODERM], 24 HR TESTOSTERONE 0.167 MG/HR TRANSDERMAL SYSTEM [ANDRODERM], TESTOSTERONE

Covered Uses
* Hypogonadism

Exclusion Criteria
N/A

Required Medical Information
1. Two separate testosterone levels drawn on different dates where the total testosterone level is below 300 ng/dL,
2. Pt experiences at least ONE of the following:
   a. malaise, b. fatigue, c. lethargy, d. muscle loss, e. depression, f. decreased libido,
3. Previous trial on generic testosterone topical or gel

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ANTIBIOTICS

Drugs
BAXDELA, DALVANCE, NUZYRA, SIVEXTro, XENLETA

Covered Uses
* Pneumonia
* Skin and Skin Structure Infection

Exclusion Criteria
N/A

Required Medical Information
Medication to be dosed based on FDA approved dosing

Age Restrictions
N/A

Prescriber Restrictions
Infectious disease specialist or after consultation with an infectious disease specialist

Coverage Duration
1 month

Other Criteria
N/A
APO B

Drugs
JUXTAPID

Covered Uses
* Low-Density Lipoprotein (LDL) level higher than 500mg/dL, Untreated, Unfasting

Exclusion Criteria
Pt has none of the following health conditions or health concerns:
   a. History of significant hepatic disease,
   b. Alcohol abuse,

Required Medical Information
1. Pt has untreated, fasting LDL cholesterol greater than 500 mg/dL AND triglycerides less than 300 mg/dL,
2. Pt meets a OR b AND c of the following:
   a. Pt has documented mutations in both alleles of the LDL receptor or of other genes known to affect LDL receptor function,
   b. Both of pt's parents have a hx of untreated total cholesterol of greater than 250 mg/dL,
   c. Pt has xanthomas present before age 10,
3. Pt has failed or is currently taking at least ONE of the following:
   a. Atorvastatin, b. Rosuvastatin, c. Simvastatin,
4. Pt has previous trial of Repatha OR Praluent

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist or Endocrinologist

Coverage Duration
1. Initial: 6 mo,
2. Reauthorization: 12 mo

Updated 2/28/2020
Other Criteria
BvsD Determination
APOKYN

Drugs
APOKYN

Covered Uses
* Parkinson's Disease

Exclusion Criteria
N/A

Required Medical Information
1. Pt suffering from end of dose wearing off episodes,
2. Apokyn initiated with a concomitant antiemetic (not a 5HT3)

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ARCALYST

Drugs
ARCALYST

Covered Uses
* Cryopyrin-Associated Periodic Syndrome (CAPS)

Exclusion Criteria
1. Combination use with a TNF-inhibitor

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
ARIKAYCE

Drugs
ARIKAYCE

Covered Uses
* Mycobacterium Avium Complex (MAC) Infection

Exclusion Criteria
N/A

Required Medical Information
1. Arikayce will be used as part of a combination antibacterial drug regimen
2. Initial:
   a. Pt has positive sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy
2. Reauth:
   a. Pt has failed to achieve sputum culture conversion by month 6

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist, Infectious Disease Specialist

Coverage Duration
Initial: 6 months
Reauth: 6 months

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage  
2020 Prior Authorization Criteria

BALVERSA

Drugs  
BALVERSA

Covered Uses  
* Urothelial Carcinoma

Exclusion Criteria  
N/A

Required Medical Information  
1. Diagnosis of locally advanced or metastatic urothelial carcinoma  
2. Confirmed fibroblast growth factor receptor (FGFR3 or FGFR2) genetic alteration  
3. Progression during or following at least one line of platinum-containing chemotherapy within 12 months

Age Restrictions  
18 years of age or older

Prescriber Restrictions  
Urologist, nephrologist, or oncologist

Coverage Duration  
Plan Year

Other Criteria  
N/A

Updated 2/28/2020
BANZEL

Covered Uses
* Lennox-Gastaut Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Pt has inadequate seizure control despite treatment with at least ONE anti-epileptic drug

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
BENLYSTA

Drugs
BENLYSTA

Covered Uses
* Systemic Lupus Erythematosus (SLE)

Exclusion Criteria
Use in severe active lupus nephritis or severe active CNS lupus

Required Medical Information
1. Pt is currently autoantibody positive,
2. Pt has current active disease,
3. Pt has previous treatment with at least TWO of the following:
   a. Corticosteroids, b. Antimalarials, c. Immunosuppressives,
4. Pt will continue to receive concomitant standard treatment with at least ONE of the following:
   a. Corticosteroids, b. Antimalarials, c. Immunosuppressives

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
BOSULIF

Drugs
BOSUTINIB 100 MG ORAL TABLET [BOSULIF], BOSUTINIB 400 MG ORAL TABLET [BOSULIF], BOSUTINIB 500 MG ORAL TABLET [BOSULIF]

Covered Uses
* Chronic Myelogenous Leukemia (CML)

Exclusion Criteria
N/A

Required Medical Information
1. Pt is diagnosed with Philadelphia chromosome positive (Ph+) CML
   a. Pt's CML is in chronic phase, accelerated phase, or blast phase,
2. Pt has previous failure or intolerance to Gleevec (imatinib)

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
BRAFTOVI

Drugs
BRAFTOVI, MEKTOVI

Covered Uses
* Malignant Melanoma

Exclusion Criteria
N/A

Required Medical Information
1) Combination use of Braftovi and Mektovi 2) BRAF V600E or V600K mutation

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, hematologist, or dermatologist

Coverage Duration
12 months

Other Criteria
N/A

Updated 2/28/2020
CABLIVI

Drugs
CABLIVI

Covered Uses
* Thrombocytopenia

Exclusion Criteria
N/A

Required Medical Information
A. Initial authorization
1. Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)
2. Started inpatient in combination with plasma exchange
B. Reauthorization
1. Signs of persistent underlying disease (e.g., suppressed ADAMTS13 concentrations)
2. Demonstrated a positive response to therapy by a clinically significant increase in platelet count, reduction in neurological symptoms, or improvement in organ-damage markers

Age Restrictions
18 years or older

Prescriber Restrictions
Hematologist

Coverage Duration
3 months

Other Criteria
N/A

Updated 2/28/2020
CABOMETYX

Drugs
CABOMETYX

Covered Uses
* Renal Cell Carcinoma (RCC)

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CALQUENCE

Drugs
ACALABRUTINIB 100 MG ORAL CAPSULE [CALQUENCE]

Covered Uses
* Mantle Cell Lymphoma (MCL)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has been treated with at least one prior therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CANDIDAS

Drugs
CASPOFUNGIN ACETATE

Covered Uses
* Aspergillosis
* Candidemia
* Esophageal Candidiasis

Exclusion Criteria
N/A

Required Medical Information
1. For invasive aspergillosis:
   a. Pt has failure on at least ONE other systemic antifungal,
2. If using for empiric therapy:
   a. Patient must be febrile AND neutropenic

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
CAPRELSA

Drugs
CAPRELSA

Covered Uses
* Thyroid Cancer

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, or Endocrinologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CARBAGLU

Drugs
CARBAGLU, KUVAN

Covered Uses
* Hyperammonemia due to N-Acetylglutamate Synthase Deficiency
* Hyperphenylalaninemia

Exclusion Criteria
N/A

Required Medical Information
1. For Carbaglu: hyperammonemia due to N-acetylglutamate synthase deficiency
2. For Kuvan: hyperphenylalaninemia due to tetra hydrobiopterin- (BH4-) responsive Phenylketonuria

Age Restrictions
N/A

Prescriber Restrictions
Specialist in Medical Genetics or Metabolic Specialist

Coverage Duration
6 Months

Other Criteria
N/A
CERDELGA

Drugs
CERDELGA

Covered Uses
* Gaucher Disease

Exclusion Criteria
N/A

Required Medical Information
1. Pt was diagnosed by a Clinical Biomedical Geneticist,
2. Pt is unable to use intravenous enzyme replacement,
3. The CYP2D6 genotype has been determined

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CESAMET

Drugs
NABILONE 1 MG ORAL CAPSULE [CESAMET]

Covered Uses
* Cancer-Associated Anorexia
* HIV-Associated Wasting Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial of olanzapine,
2. Pt has previous trial of dronabinol

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CHOLBAM

Drugs
CHOLBAM

Covered Uses
* Bile Acid Synthesis Disorders
* Peroxisomal Disorders (PDs)
* Zellweger Spectrum Disorder

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt has abnormal results from a urinary bile acids analysis by FAB-MS and neurologic exam,
2. Reauth:
   a. After at least 3 mo of therapy ALT and AST values have been reduced to less than 50 U/L OR baseline reduced by 80%,
   b. After at least 3 mo of therapy total bilirubin values have been reduced to less than or equal to 1 mg/dl,
   c. Pt's body weight has increased by 10% or is stable at the greater than 50th percentile OR liver biopsy shows no evidence of cholestasis since initiation of therapy

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist

Coverage Duration
Initial: 6 months,
Reauth: 12 months

Updated 2/28/2020
Other Criteria
N/A
CIMZIA

Drugs
CIMZIA

Covered Uses
* Ankylosing Spondylitis
* Psoriatic Arthritis (PsA)
* Rheumatoid Arthritis (RA)

Exclusion Criteria
Combination therapy with TNF antagonist

Required Medical Information
1. RA dx: Pt has failed on at least ONE of the following:
   a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, e. injectable gold, f. oral gold, g. azathioprine, h. penicillamine, i. cyclosporine,

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Gastroenterologist, or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
COMETRIQ

Drugs
COMETRIQ

Covered Uses
* Metastatic Medullary Thyroid Carcinoma

Exclusion Criteria
Diagnosis of indolent medullary thyroid cancer

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
**COPIKTRA**

**Drugs**
COPIKTRA

**Covered Uses**
- Chronic Lymphocytic Leukemia (CLL)
- Follicular Lymphoma
- Small Lymphocytic Leukemia (SLL)

**Exclusion Criteria**
N/A

**Required Medical Information**
Previous use of 2 prior therapies for indication

**Age Restrictions**
N/A

**Prescriber Restrictions**
hematologist or oncologist

**Coverage Duration**
12 months

**Other Criteria**
N/A

Updated 2/28/2020
COSENTYX

Drugs
1 ML SECUKINUMAB 150 MG/ML AUTO-INJECTOR [COSENTYX], 1 ML SECUKINUMAB 150 MG/ML PREFILLED SYRINGE [COSENTYX]

Covered Uses
* Ankylosing Spondylitis
* Plaque Psoriasis
* Psoriatic Arthritis (PsA)

Exclusion Criteria
N/A

Required Medical Information
1. Ankylosing spondylitis dx:
2. Psoriatic arthritis dx:
   a. Pt has previous failure of at least ONE of the following:

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist or Rheumatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CRINONE

Drugs
PROGESTERONE 0.04 MG/MG VAGINAL GEL [CRINONE]

Covered Uses
* Amenorrhea

Exclusion Criteria
N/A

Required Medical Information
A. Diagnosis of secondary amenorrhea

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
CYSTAGON

Drugs
CYSTEAMINE 150 MG ORAL CAPSULE [CYSTAGON], CYSTEAMINE 50 MG ORAL CAPSULE [CYSTAGON]

Covered Uses
* Nephrotic Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of nephropathic cystinosis
2. Elevated baseline WBC cysteine levels greater than 2 nmol per 1/2 cystine/mg protein
3. CTNS gene mutation
4. Clinical symptoms of an electrolyte imbalance and polyuria

Age Restrictions
N/A

Prescriber Restrictions
Nephrologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

CYSTARAN

Drugs
CYSTARAN

Covered Uses
* Cystinosis

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt has corneal cysteine accumulation that has been confirmed by slit-lamp photography,
2. Reauth:
   a. Must meet ONE of the following:
      i. Pt had a reduction of 1 or more units in the Corneal Cystine Crystal Score (CCCS) after 6 months of treatment with Cystaran
      ii. Pt has lack of increase of more than one unit in CCCS when baseline CCCS was less than 1

Age Restrictions
N/A

Prescriber Restrictions
Corneal Specialist, Endocrinologist, or Ophthalmologist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

CYSTIC FIBROSIS

Drugs
BETHKIS, CAYSTON, TOBRAMYCIN

Covered Uses
* Cystic Fibrosis

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had at least ONE positive culture for Pseudomonas aeruginosa
2. If request not for generic tobramycin: Previous trial on generic tobramycin

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Infectious Disease Specialist

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
DAURISMO

Drugs
GLASDEGIB 100 MG ORAL TABLET [DAURISMO], GLASDEGIB 25 MG ORAL TABLET [DAURISMO]

Covered Uses
* Acute Myelogenous Leukemia (AML)

Exclusion Criteria
N/A

Required Medical Information
1. Equal to or greater than 75 years or has comorbidity preventing use of intensive induction chemotherapy.
2. Be given in combination with low-dose cytarabine

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or hematologist

Coverage Duration
Plan year

Other Criteria
N/A

Updated 2/28/2020
DEPEN

Drugs
PENICILLAMINE 250 MG ORAL TABLET [DEPEN]

Covered Uses
- Cystinuria
- Wilson Disease

Exclusion Criteria
N/A

Required Medical Information
1. For cystinuria dx:
   a. Pt has failure of conservative treatment measures including the following:
      i. High fluid intake,
      ii. Sodium and protein restriction,
      iii. Urinary alkalization with potassium citrate, potassium bicarbonate, or acetazolamide,
   b. Pt has previous failure with Thiola.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
DIFICID

Drugs
DIFICID

Covered Uses
* Clostridium Difficile (C.Diff) associated Diarrhea

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had a positive C. difficile toxin assay within the past month,
2. Pt has tried the following treatments:
   a. Vancomycin for 10-14 days,
   b. Vancomycin extended taper,

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist or Infectious Disease Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
DOPTELET

Drugs
DOPTELET

Covered Uses
* Thrombocytopenia

Exclusion Criteria
N/A

Required Medical Information
1. Platelet count less than 50,000
2. Pt is scheduled for a procedure where there is a bleeding risk
3. Doptelet will be used for 5 days starting 10 to 13 days prior to the procedure and discontinued 5 to 8 days prior to the procedure
4. For chronic immune thrombocytopenia, has the patient had an insufficient response to a previous treatment (e.g. corticosteroid, immune globulin)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

DRONABINOL

Drugs
TETRAHYDROCANNABINOL 10 MG ORAL CAPSULE, TETRAHYDROCANNABINOL 2.5 MG ORAL CAPSULE, TETRAHYDROCANNABINOL 5 MG ORAL CAPSULE

Covered Uses
* Cancer-Associated Anorexia
* HIV-Associated Wasting Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. For HIV-associated wasting syndrome OR cancer-associated anorexia dx:
   a. Pt has previous trial on megestrol,
2. For CINV dx:
   a. Pt has previous trial on olanzapine

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
DUPIXENT

Drugs
1.14 ML DUPILUMAB 175 MG/ML PREFILLED SYRINGE [DUPIXENT], 2 ML DUPILUMAB 150 MG/ML PREFILLED SYRINGE [DUPIXENT]

Covered Uses
* Atopic Dermatitis

Exclusion Criteria
N/A

Required Medical Information
1. Atopic dermatitis involves 10% body surface area or more,
2. Pt has previous trail on tacrolimus 0.1% ointment,
3. Pt has previous trail on at least ONE of the following:

Age Restrictions
12 years old or older

Prescriber Restrictions
Allergist, Dermatologist, Immunologist, or ENT

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
EMGALITY

Drugs
1 ML GALCANEZUMAB-GNLM 100 MG/ML PREFILLED SYRINGE [EMGALITY], 1 ML GALCANEZUMAB-GNLM 120 MG/ML AUTO-INJECTOR [EMGALITY], 1 ML GALCANEZUMAB-GNLM 120 MG/ML PREFILLED SYRINGE [EMGALITY]

Covered Uses
* Migraine

Exclusion Criteria
1. Pt has received botulinum injections for migraine prophylaxis in the past 3 months,
2. Aimovig will be used in combination with botulinum toxin migraine prophylaxis therapy

Required Medical Information
1. Initial:
   a. Pt experiences greater than or equal to 4 migraine days per month,
   b. Pt has trial on prophylactic therapy on at least TWO of the following:
      i. Anti-epileptic drug,
      ii. Beta-blocker,
      iii. Antidepressant
2. Diagnosis of episodic cluster headache
3. Reauth for chronic or episodic migraine:
   a. Pt has had a reduction in migraine days of at least 2 per month

Age Restrictions
N/A

Prescriber Restrictions
Neurologist, Headache Specialist

Coverage Duration
Initial: 6 Months

Updated 2/28/2020
Reauth: Plan Year

Other Criteria
N/A
ENBREL

Drugs
ENBREL, ENBREL MINI, ENBREL SURECLICK

Covered Uses
* Ankylosing Spondylitis
* Plaque Psoriasis
* Psoriatic Arthritis (PsA)
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. RA, JRA, PsA dx: Pt has failed at least three months therapy on at least ONE of the following:
   a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, e. injectable gold, f. oral gold, g. azathioprine, h. penicillamine, i. cyclosporine

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Dermatologist, or Gastroenterologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ENDOTHELIN ANTAGONIST

Drugs
AMBRISENTAN, BOSENTAN, OPSUMIT, TRACLEER

Covered Uses
* Pulmonary Arterial Hypertension (PAH)

Exclusion Criteria
N/A

Required Medical Information
1. Exclusion of all secondary causes of pulmonary hypertension,
2. Must be dx with PAH with WHO class II, III, or IV

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Cardiologist

Coverage Duration
Plan Year

Other Criteria
N/A
EPCLUSA

Drugs
SOFOSBUVIR/VELPATASVIR

Covered Uses
* Hepatitis C Virus (HCV), Genotype 2
* Hepatitis C Virus (HCV), Genotype 3
* Hepatitis C Virus (HCV), Genotype 5
* Hepatitis C Virus (HCV), Genotype 6

Exclusion Criteria
N/A

Required Medical Information
1. Chart notes documenting genotype,

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

Coverage Duration
12 Weeks

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

EPIDIOLEX

Drugs
EPIDIOLEX

Covered Uses
* Dravet Syndrome
* Lennox-Gastaut Syndrome

Exclusion Criteria
N/A

Required Medical Information
Previous use of two alternative antiepileptic medications and used in combination with another antiepileptic

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
12 months

Other Criteria
N/A

Updated 2/28/2020
ERIVEDGE

Drugs
ERIVEDGE, ODOMZO

Covered Uses
* Basal Cell Carcinoma

Exclusion Criteria
N/A

Required Medical Information
1. Pt has recurring lesions after radiation therapy OR radiation therapy is contraindicated or inappropriate,
2. Pt has recurring lesions after surgical excision OR surgery is contraindicated or inappropriate

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ERLEADA

Drugs
ERLEADA

Covered Uses
* Prostate Cancer

Exclusion Criteria
N/A

Required Medical Information
Must meet at least ONE of the following:
1. Erleada will be given combination with a gonadotropin-releasing hormone analog
2. Patient has had a bilateral orchiectomy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
EVENITY

Drugs
EVENITY

Covered Uses
* Osteoporosis

Exclusion Criteria
Myocardial infarction or stroke in the last 12 months

Required Medical Information
1. Patient is female
2. Patient is postmenopausal
3. Diagnosis of osteoporosis (t-score less than -2.5) or osteopenia (t-score of -1.0 to -2.5)
4. Previous use of both:
   A. Bisphosphonate therapy
   B. Prolia
5. At least one of the following:
   A. Previous osteoporotic fracture
   B. Bone loss based on the results of DEXA scans showing 10 percent or greater bone loss at spine or hip over the past two years
   C. A fasting morning serum C-telopeptide less than 200 pg/ml OR a 24-hour urine N-telopeptide less than 50 nM BCE/mM creatinine

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, rheumatologist, gynecologist, orthopedist, or mid-level provider with a supervising physician in one of these specialties

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
N/A
FARESTON

Drugs
TOREMIFENE CITRATE

Covered Uses
* Metastatic Breast Cancer

Exclusion Criteria
1. Pt has congenital or acquired QT prolongation,
2. Pt has uncorrected hypokalemia,
3. Pt has uncorrected hypomagnesemia

Required Medical Information
1. Pt has previous trial and failure or contraindication to tamoxifen therapy,
2. Pt has previous trial and failure or contraindication to aromatase inhibitor therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
FARYDAK

Drugs
PANOBINOSTAT 10 MG ORAL CAPSULE [FARYDAK], PANOBINOSTAT 15 MG ORAL CAPSULE [FARYDAK], PANOBINOSTAT 20 MG ORAL CAPSULE [FARYDAK]

Covered Uses
* Multiple Myeloma

Exclusion Criteria
N/A

Required Medical Information
1. Used in combination with bortezomib and dexamethasone,
2. Pt has previous trial on at least TWO regimens including bortezomib and an immunomodulatory agent

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
FASENRA

Drugs
1 ML BENRALIZUMAB 30 MG/ML AUTO-INJECTOR [FASENRA], 1 ML BENRALIZUMAB 30 MG/ML PREFILLED SYRINGE [FASENRA], 1 ML MEPOLIZUMAB 100 MG/ML AUTO-INJECTOR [NUCALA], 1 ML MEPOLIZUMAB 100 MG/ML PREFILLED SYRINGE [NUCALA]

Covered Uses
* Asthma

Exclusion Criteria
N/A

Required Medical Information
1. Pt has a hx of 1 or more exacerbations requiring the use of oral corticosteroids in the past 12 months,
2. Pt has previously been on all of the following:
   a. High-dose corticosteroid/Long-acting inhaled bronchodilator combination
   b. Tiotropium bromide,
3. Pt peripheral blood eosinophil level is greater than or equal to 150 cells/mcL within the last 6 months OR greater than equal to 300 cells/mcL within the last 12 months

Age Restrictions
N/A

Prescriber Restrictions
Allergist, Pulmonologist, or Rheumatologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
FENTANYL

Drugs
ABSTRAL, FENTANYL 0.2 MG ORAL LOZENGE, FENTANYL 0.4 MG ORAL LOZENGE, FENTANYL 0.6 MG ORAL LOZENGE, FENTANYL 0.8 MG ORAL LOZENGE, FENTANYL 1.2 MG ORAL LOZENGE, FENTANYL 1.6 MG ORAL LOZENGE, FENTANYL CITRATE, LAZANDA

Covered Uses
* Moderate to Severe Pain associated with Cancer

Exclusion Criteria
Non-cancer pain use

Required Medical Information
1. Must have documented maintenance therapy with a long-acting opioid,
2. Documented failure with a short-acting opioid for breakthrough pain

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Pain Specialist

Coverage Duration
6 Months

Other Criteria
Previous trial on generic fentanyl citrate

Updated 2/28/2020
FIRAZYR

Drugs
3 ML ICATIBANT 10 MG/ML PREFILLED SYRINGE

Covered Uses
* Angioedema

Exclusion Criteria
N/A

Required Medical Information
1. For HAE type I and II and acquired angioedema:
   a. Dx has been verified by low C1-INH and/or low C1-INH function levels on two separate occasions,
2. For HAE with normal C1-INH:
   a. Pt has failed a trial with high-dose non-sedating antihistamines such as cetirizine, desloratadine, or levocetirizine for at least 30 days to rule-out idiopathic angioedema

Age Restrictions
N/A

Prescriber Restrictions
Allergist or Immunologist

Coverage Duration
1. Initial: 3 mo,
2. Reauth: 1 year

Other Criteria
N/A

Updated 2/28/2020
FIRDAPSE

Drugs
FIRDAPSE, RUZURGI

Covered Uses
* Lambert-Eaton myasthenic syndrome

Exclusion Criteria
N/A

Required Medical Information
I. Initial authorization
   A. P/Q-type voltage-gated calcium channel antibodies
   B. Repetitive nerve stimulation consistent with LEMS
   C. Screening for cancer related to LEMS
   D. Experiences moderate to severe weakness interfering with function
   E. Documentation of quantitative myasthenia gravis core and subjective global impression score
II. Reauthorization
   A. Improvements in myasthenia gravis core and subjective global impression score
   B. Screened 3-6 months after initial screening for malignancies

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 3 months
Reauthorization: 6 months

Updated 2/28/2020
Other Criteria
N/A
FLUOROURACIL

Drugs
FLUOROURACIL

Covered Uses
* Actinic Keratosis

Exclusion Criteria
If female: Pt is pregnant or planning to become pregnant

Required Medical Information
Pt has previous trial on at least TWO of the following:
  1. Fluorouracil 2% Solution
  2. Fluorouracil 5% Cream
  3. Fluorouracil 5% Solution
  4. Imiquimod 5% Cream

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
FORTEO

Drugs
28 ACTUAT TERIPARATIDE 0.02 MG/ACTUAT PEN INJECTOR [FORTEO]

Covered Uses
* Osteoporosis

Exclusion Criteria
1. Treatment for longer than 2 years

Required Medical Information
1. For osteoporosis dx:
   a. Required WHO FRAX has been completed and pt is determined to be high risk with a 10 year hip fracture probability of greater than 10%,
   b. Pt is intolerant or has a contraindication to Tymlos,
   c. Pt has previous use of Prolia and failed therapy as evidenced by fragility fracture or a decline in bone mineral density of greater than 10% while on therapy.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD

Updated 2/28/2020
GALAFOlad

Drugs
GALAFOlad

Covered Uses
* Fabry Disease

Exclusion Criteria
N/A

Required Medical Information
amenable galactosidase alpha gene variant

Age Restrictions
16 years of age or older

Prescriber Restrictions
Clinical geneticist or biochemical geneticist

Coverage Duration
Plan year

Other Criteria
N/A

Updated 2/28/2020
GATTEX

Drugs
GATTEX

Covered Uses
* Short Bowel Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Pt has been dependent on parenteral nutrition or intravenous support for at least 12 months,
2. Pt has required parenteral nutrition at least 3 times per week for at least 12 months,
3. Pt has undergone colonoscopy of the entire colon within the past 6 months

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist

Coverage Duration
Initial: 6 months,
Reauth: Plan Year

Other Criteria
N/A

Updated 2/28/2020
GILOTRIF

Drugs
AFATINIB 20 MG ORAL TABLET [GILOTRIF], AFATINIB 30 MG ORAL TABLET [GILOTRIF], AFATINIB 40 MG ORAL TABLET [GILOTRIF]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1. Metastatic Squamous NSCLC dx:
   a. Progression after platinum-based chemotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
GLEOSTINE

Drugs
GLEOSTINE

Covered Uses
* Brain Cancer
* Hodgkin’s Lymphoma

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
GROWTH HORMONE

Drugs
1.5 ML SOMATROPIN 3.3 MG/ML CARTRIDGE [OMNITROPE], 1.5 ML SOMATROPIN 6.67 MG/ML CARTRIDGE [OMNITROPE], SAIZEN, SAIZENPREP RECONSTITUTION, SOMATROPIN 5 MG/ML INJECTABLE SOLUTION [OMNITROPE]

Covered Uses
* AIDs-Related Wasting
* Chronic Renal Insufficiency
* Growth Hormone Deficiency (GHD)
* Prader-Willi Syndrome
* Short Stature Disorder
* Small for Gestational Age (SGA)
* Turner’s Syndrome

Exclusion Criteria
1. For Ped GHD:
   Male at bone age of 16 yo, Female at bone age of 14 yo,
2. Fusion of epiphyses
3. Reauth: Growth velocity is less than 2 cm/yr,

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Ped GHD AND Adult GHD: Endocrinologist

Coverage Duration
1. Ped GHD:

Updated 2/28/2020
Initial: 6 mo,  
Reauth: 12 mo,  
2. HIV wasting: 48 wks LIFETIME,  
3. All others: Plan Year  

Other Criteria  
1. Chronic Renal Insufficiency:  
a. Meet ALL of the following:  
i. Pt dxed with CRI AND has not yet received renal transplant,  
ii. Existing metabolic disorders have been corrected,  
iii. Ht more than 2 SD below the population mean OR less than 3rd percentile,  
iv. Height velocity less than 4cm/yr or less than 10th percentile of normal for age and gender,  
2. Turner Syndrome:  
a. Meet ALL of the following:  
i. Dx of TS confirmed by blood karotype or fibroblast studies,  
ii. Ht of female pt plotted on TS-specific growth curve AND pt is less than 5th percentile of normal growth curve for girls,  
3. Prader-Willi Syndrome:  
a. Meet ALL of the following:  
i. Dx of PWS confirmed by appropriate genetic testing,  
ii. Ht more than 2 SD below the pop mean OR less than 3rd percentile,  
iii. Ht velocity less than 3cm/yr or less than 10th percentile of normal for age and gender,  
4. Small for Gestational Age:  
a. Meet ALL of the following:  
i. Dx of SGA as defined as one of the following:  
   (1) Birth weight of less than 2,500g at gestational age of greater than 37 weeks,  
   (2) OR birth weight or length less than 3rd percentile for gestational age,  
ii. Pt has failed to catch up in ht by 2 yo,  
5. AIDS-Related Wasting:  
a. Meet ALL of the following:  
i. Involuntary weight loss of more than 10% pre-illness body weight or a BMI less than 20,  
ii. Failure to respond to dronabinol (Marinol) OR megesterol acetate (Megace),  
iii. Chronic diarrhea (defined as more than 3 loose stools/day for more than 30 days) OR Chronic weakness and documented fever (30 days, intermittent or constant) in the absence of concurrent illness or condition other than HIV infection that would otherwise explain the symptoms.

Updated 2/28/2020
HAEGARDA

Drugs
HAEGARDA, TAKHZYRO

Covered Uses
* Hereditary Angioedema

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Dx of HAE type I or II has been verified by low C1-INH and/or low C1-INH functional levels on two separate occasions
   b. Pt has a history of 5 or more facial, laryngeal, and/or gastrointestinal HAE attacks per month
   c. Pt is compliant with trigger avoidance
   d. Pt has failed at least a 30 day trial of attenuated androgen therapy OR there is a contraindication to attenuated androgen therapy
2. Reauthorization:
   a. Pt had a significant decrease in the frequency of attacks per month (at least 50 percent decrease), or had a significant decrease in the severity or duration of attacks

Age Restrictions
N/A

Prescriber Restrictions
Allergist or Immunologist who evaluates and treats HAE

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
HARVONI

Drugs
LEDIPASVIR/SOFOSBUVIR

Covered Uses
* Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV) Co-Infection
* Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) Co-Infection
* Hepatitis C Virus (HCV), Genotype 1a
* Hepatitis C Virus (HCV), Genotype 1b
* Hepatitis C Virus (HCV), Genotype 3
* Hepatitis C Virus (HCV), Genotype 4
* Hepatitis C Virus (HCV), Genotype 5
* Hepatitis C Virus (HCV), Genotype 6

Exclusion Criteria
N/A

Required Medical Information
1. Chart notes showing genotype

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

Coverage Duration
Maximum 24 weeks

Other Criteria
N/A

Updated 2/28/2020
HEPATITIS C

Drugs
0.5 ML PEGINTERFERON ALFA-2A 0.36 MG/ML AUTO-INJECTOR [PEGASYS], 0.5 ML PEGINTERFERON ALFA-2A 0.36 MG/ML PREFILLED SYRINGE [PEGASYS], 1 ML PEGINTERFERON ALFA-2A 0.18 MG/ML INJECTION [PEGASYS]

Covered Uses
* Hepatitis B Virus (HBV)
* Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV) Co-Infection
* Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) Co-Infection
* Hepatitis C Virus (HCV), Genotype 1a
* Hepatitis C Virus (HCV), Genotype 1b
* Hepatitis C Virus (HCV), Genotype 2
* Hepatitis C Virus (HCV), Genotype 3
* Hepatitis C Virus (HCV), Genotype 4
* Hepatitis C Virus (HCV), Genotype 5
* Hepatitis C Virus (HCV), Genotype 6

Exclusion Criteria
N/A

Required Medical Information
1. For Hep B dx:
   a. Pre-treatment HBV DNA levels are greater than 20,000 IU/ml,
   b. Must be used as monotherapy
2. Hep C dx

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist or Infectious Disease

Updated 2/28/2020
Coverage Duration
48 weeks

Other Criteria
N/A
HETLIOZ

Drugs
HETLIOZ

Covered Uses
* Non-24 Hour Sleep-Wake Disorder

Exclusion Criteria
N/A

Required Medical Information
Pt is totally blind without light perception

Age Restrictions
N/A

Prescriber Restrictions
Sleep specialist or Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
**SelectHealth Advantage**

**2020 Prior Authorization Criteria**

**HUMIRA**

**Drugs**

0.1 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA], 0.2 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA], 0.2 ML ADALIMUMAB 50 MG/ML PREFILLED SYRINGE [HUMIRA], 0.4 ML ADALIMUMAB 100 MG/ML PEN INJECTOR [HUMIRA], 0.4 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA], 0.4 ML ADALIMUMAB 50 MG/ML PREFILLED SYRINGE [HUMIRA], 0.8 ML ADALIMUMAB 50 MG/ML AUTO-INJECTOR [HUMIRA], 0.8 ML ADALIMUMAB 50 MG/ML PREFILLED SYRINGE [HUMIRA], {1 (0.4 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA]) / 1 (0.8 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA])} PACK [HUMIRA PEDIATRIC CROHN'S DISEASE STARTER PACKAGE (2 COUNT)], {2 (0.4 ML ADALIMUMAB 100 MG/ML PEN INJECTOR [HUMIRA]) / 1 (0.8 ML ADALIMUMAB 100 MG/ML PEN INJECTOR [HUMIRA])} PACK [HUMIRA PEN 80 MG/0.8 ML AND 40 MG/0.4 ML - PSORIASIS/UVEITIS STARTER PACKAGE], {3 (0.8 ML ADALIMUMAB 100 MG/ML PEN INJECTOR [HUMIRA])} PACK [HUMIRA PEN 80 MG/0.8 ML - STARTER PACKAGE FOR CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA], {3 (0.8 ML ADALIMUMAB 100 MG/ML PREFILLED SYRINGE [HUMIRA])} PACK [HUMIRA PEDIATRIC CROHN'S DISEASE STARTER PACKAGE (3 COUNT)], {4 (0.8 ML ADALIMUMAB 50 MG/ML AUTO-INJECTOR [HUMIRA])} PACK [HUMIRA PEN - PSORIASIS STARTER PACK], {6 (0.8 ML ADALIMUMAB 50 MG/ML AUTO-INJECTOR [HUMIRA])} PACK [HUMIRA PEN - CROHN'S DISEASE STARTER PACK], {6 (0.8 ML ADALIMUMAB 50 MG/ML PREFILLED SYRINGE [HUMIRA])} PACK [HUMIRA PEDIATRIC CROHN'S DISEASE STARTER PACKAGE (6 COUNT)]

**Covered Uses**

- Ankylosing Spondylitis
- Hidradenitis Suppurativa
- Juvenile Idiopathic Arthritis (JIA)
- Noninfectious Uveitis
- Plaque Psoriasis
- Psoriatic Arthritis (PsA)
- Rheumatoid Arthritis (RA)
- Ulcerative Colitis (UC)

**Exclusion Criteria**

N/A

**Required Medical Information**

1. RA, JRA, PsA dx:
   a. Pt has failed at least three months therapy on at least ONE of the following:
      i. methotrexate, ii. leflunomide, iii. hydroxychloroquine, iv. sulfasalazine, v. injectable gold, vi. oral gold, vii. azathioprine, viii. penicillamine, ix.

Updated 2/28/2020
cyclosporine,
2. Hidradenitis suppurativa dx:
   a. Pt has lesions present in at least two distinct anatomical areas, one of which is Hurley Stage II or III
3. Noninfectious uveitis dx:
   a. Pt has previous failure on corticosteroids

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Dermatologist, Gastroenterologist, or Ophthalmologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

HUMULIN U500

Drugs
3 ML REGULAR INSULIN, HUMAN 500 UNT/ML PEN INJECTOR [HUMULIN R], REGULAR INSULIN, HUMAN 500 UNT/ML INJECTABLE SOLUTION [HUMULIN R]

Covered Uses
* Diabetes Mellitus

Exclusion Criteria
N/A

Required Medical Information
1. Requires more than 200 units of insulin per day

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

IBRANCE

Drugs
PALBOCICLIB 100 MG ORAL CAPSULE [IBRANCE], PALBOCICLIB 125 MG ORAL CAPSULE [IBRANCE], PALBOCICLIB 75 MG ORAL CAPSULE [IBRANCE]

Covered Uses
* Breast Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Ibrance used as initial therapy:
   a. Used in combination with an aromatase inhibitor,
2. Ibrance used after endocrine-based therapy:
   a. Used in combination with fulvestrant,
   b. If pt is pre- or perimenopausal: Ibrance and fulvestrant used in combination with a luteinizing hormone-releasing hormone agonist

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ICLUSIG

Drugs
ICLUSIG

Covered Uses
* Acute Lymphocytic Leukemia (ALL)
* Chronic Myelogenous Leukemia (CML)

Exclusion Criteria
N/A

Required Medical Information
1. CML dx:
   a. Pt's CML is in chronic phase, accelerated phase, or blast phase,
2. ALL dx:
   a. Pt has previous trial on Gleevec

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage  
2020 Prior Authorization Criteria

IDHIFA

Drugs  
IDHIFA

Covered Uses  
* Acute Myelogenous Leukemia (AML)

Exclusion Criteria  
N/A

Required Medical Information  
1. Cancer has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a FDA-approved test,  
2. Pt has relapsed or is refractory to one or more prior anticancer regimens

Age Restrictions  
N/A

Prescriber Restrictions  
Oncologist or Hematologist

Coverage Duration  
Plan Year

Other Criteria  
BvsD Determination

Updated 2/28/2020
ILUMYA

Drugs
ILUMYA

Covered Uses
* Plaque Psoriasis

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial on TWO of:
   Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
IMBRUVICA

Drugs
IMBRUVICA

Covered Uses

* Chronic Graft versus Host Disease (cGVHD)
* Chronic Lymphocytic Leukemia (CLL)
* Mantle Cell Lymphoma (MCL)
* Marginal Zone Lymphoma
* Small Lymphocytic Leukemia (SLL)
* Waldenstrom’s Macroglobulinemia

Exclusion Criteria
N/A

Required Medical Information
Pt has failed at least ONE prior therapy

Age Restrictions
N/A

Prescriber Restrictions
1. cGVHD: Transplant Specialist
2. All other dx: Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
IMMUNOTHERAPY

Drugs
ORALAIR

Covered Uses
* Allergic Rhinitis
* Asthma

Exclusion Criteria
Pt has severe, unstable, or uncontrolled asthma

Required Medical Information
1. Initial:
   a. Pt has experienced allergy symptoms due to grass-pollen induced allergic rhinitis,
   b. Pt has previous trial and failure of at least ONE intranasal corticosteroid AND at least ONE oral antihistamine,
   c. Pt will be started on the therapy in an appropriate timeframe before allergy season as follows:
      i. Started 12 weeks prior to the beginning of grass pollen season,
      ii. For Oralair: Started at least 16 weeks prior to the beginning of grass pollen season,
2. Reauth:
   a. Documentation of positive clinical response to therapy

Age Restrictions
Between 10 and 65

Prescriber Restrictions
Allergist or Immunologist

Coverage Duration
10 Months

Other Criteria
N/A
Updated 2/28/2020
INBRIJA

Drugs
INBRIJA

Covered Uses
* Parkinson's Disease

Exclusion Criteria
Asthma, COPD, or other chronic lung disease

Required Medical Information
1. Diagnosis of Parkinson's disease
2. Current use of 3 or more doses per day of carbidopa-levodopa
3. Two or more hours of off time per day
4. Previous use of two alternatives (entacapone, selegiline, rasagiline, pramipexole, bromocriptine, ropinirole)

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
INCRELEX

Drugs
INCRELEX

Covered Uses
* Primary Insulin-Like Growth Hormone Factor (IGF-1) Deficiency

Exclusion Criteria
N/A

Required Medical Information
1. Height standard deviation score of less than -3 based on age and gender,
2. Basal IGF-1 standard deviation score of less than -3 based on age and gender,
3. Normal or elevated growth hormone levels,
4. Pt must have open epiphyses,
5. Gh stimulation test of greater than 10 mcg/L.

Age Restrictions
2 years old or older

Prescriber Restrictions
Endocrinologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
INGREZZA

Drugs
INGREZZA

Covered Uses
* Tardive Dyskinesia

Exclusion Criteria
N/A

Required Medical Information
Pt has previous trial on tetrabenazine

Age Restrictions
N/A

Prescriber Restrictions
Movement Disorder Specialist, Neurologist, or Psychiatrist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
INLYTA

Drugs
AXITINIB 1 MG ORAL TABLET [INLYTA], AXITINIB 5 MG ORAL TABLET [INLYTA]

Covered Uses
* Renal Cell Carcinoma (RCC)

Exclusion Criteria
N/A

Required Medical Information
Pt has failed prior systemic therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
INREBIC

Drugs
INREBIC

Covered Uses
* Myelofibrosis

Exclusion Criteria
Intolerance, failure, or previous use of ruxolitinib

Required Medical Information
A. Diagnosis of intermediate or high-risk primary or secondary myelofibrosis
B. Platelet count greater than or equal to 50x10^9/L

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
IRESSA

Drugs
GEFITINIB 250 MG ORAL TABLET [IRESSA]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has ONE of the following:
   a. EGFR exon 19 deletion,
   b. EGFR exon 21 deletion,
2. Iressa is used as first-line therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

IVIG

Drugs
25 ML IMMUNOGLOBULIN G, HUMAN 100 MG/ML INJECTION [GAMMAGARD], BIVIGAM, FLEBOGAMMA DIF, GAMMAKED, GAMMAPLEX, GAMUNEX-C, IMMUNOGLOBULIN G, HUMAN 10000 MG INJECTION [GAMMAGARD], IMMUNOGLOBULIN G, HUMAN 5000 MG INJECTION [GAMMAGARD], OCTAGAM, PRIVIGEN

Covered Uses
* Antibody Deficiency with Normal Serum Immunoglobin Levels
* Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
* Chronic Lymphocytic Leukemia (CLL)
* Common Variable Immunodeficiency
* Congenital Agammaglobulinemia
* Dermatomyositis
* Guillain-Barre Syndrome
* Immune Mediated Blistering Disease (pemphigus/pemphigoid), Clinically Confirmed
* Immune Mediated Thrombocytopenia
* Kawasaki Syndrome
* Multiple Sclerosis (MS)
* Polymyositis
* Primary Immunodeficiency
* Severe Combined Immunodeficiency
* Specific (Qualitative) Antibody Deficiency Syndrome
* Stevens-Johnson Syndrome
* Stiff Person Syndrome
* Toxic Epidermal Necrolysis
* Wiskott-Aldrich Syndrome
* X-Linked with Hyperimmunoglobulin M Immunodeficiency

Exclusion Criteria
N/A

Required Medical Information
N/A

Updated 2/28/2020
Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
JADENU

Drugs
DEFERASIROX, DEFERASIROX 180 MG ORAL GRANULES [JADENU], DEFERASIROX 180 MG ORAL TABLET [JADENU], DEFERASIROX 360 MG ORAL GRANULES [JADENU], DEFERASIROX 90 MG ORAL GRANULES [JADENU]

Covered Uses
* Iron Toxicity
* Transfusional Iron Overload

Exclusion Criteria
N/A

Required Medical Information
1. For blood transfusion dx:
   a. Pt's serum ferritin is greater than 1000 mcg/L,
   b. Pt has failed subcutaneous deferoxamine through an inability to achieve desired goals of therapy or been intolerant to therapy,
2. For non-transfusion-dependent thalassemia dx:
   a. Pt's liver iron concentration is at least 5 mg Fe per gram of dry weight,
   b. Pt's serum ferritin is greater than 300 mcg/L,
   c. Pt has failed subcutaneous deferoxamine through an inability to achieve desired goals of therapy or been intolerant to therapy

Age Restrictions
1. For blood transfusion dx: 2 years old and older,
2. For non-transfusion-dependent thalassemia dx: 10 years old and older

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
N/A
JAKAFI

Drugs
JAKAFI

Covered Uses
* Graft versus host disease (GVHD)
* Myelofibrosis
* Polycythemia Vera (PV)
* Post-Polycythemia Vera Myelofibrosis
* Thrombocythemia Myelofibrosis

Exclusion Criteria
N/A

Required Medical Information
1. Must have at least ONE of the following:
   a. Pt has enlarged spleen shown by MRI or CT,
   b. Pt has palpable splenomegaly,
2. Platelet count greater than or equal to 50X10(9)/L
3. Treatment of acute graft versus host disease

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 2/28/2020
JYNARQUE

Drugs
JYNARQUE

Covered Uses
* Polycystic Kidney Disease

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of autosomal dominant polycystic kidney disease

Age Restrictions
N/A

Prescriber Restrictions
Nephrologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
KALYDECO

Drugs
KALYDECO

Covered Uses
* Cystic Fibrosis

Exclusion Criteria
N/A

Required Medical Information
1. Pt genotyped by an FDA-cleared CF mutation test,
2. Pt have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data

Age Restrictions
Tablet: 6 years old or older,
Granules: 6 months old to 5 years old

Prescriber Restrictions
Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
KEVZARA

Drugs
1.14 ML SARILUMAB 132 MG/ML PREFILLED SYRINGE [KEVZARA], 1.14 ML SARILUMAB 175 MG/ML PREFILLED SYRINGE [KEVZARA]

Covered Uses
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has persistent active disease and been treated for at least 3 months
2. Pt has previous trial on at least TWO of:
   Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
18 yo or older

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
KINERET

Drugs
KINERET

Covered Uses
* Juvenile Idiopathic Arthritis (JIA)
* Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial on at least TWO:
   Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage  
2020 Prior Authorization Criteria  

**KISQALI**

**Drugs**
{21 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI 200 MG DAILY DOSE CARTON], {28 (LETROZOLE 2.5 MG ORAL TABLET [FEMARA]) / 21 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI FEMARA CO-PACK 200], {28 (LETROZOLE 2.5 MG ORAL TABLET [FEMARA]) / 42 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI FEMARA CO-PACK 400], {28 (LETROZOLE 2.5 MG ORAL TABLET [FEMARA]) / 63 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI FEMARA CO-PACK 600], {42 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI 400 MG DAILY DOSE CARTON], {63 (RIBOCICLIB 200 MG ORAL TABLET [KISQALI]) } PACK [KISQALI 600 MG DAILY DOSE CARTON]

**Covered Uses**
* Breast Cancer

**Exclusion Criteria**
N/A

**Required Medical Information**
1. Must meet ONE of the following:
   a. Pt will receive an aromatase inhibitor in combination with Kisqali as initial endocrine based therapy for advanced or metastatic disease,
   b. Pt will receive fluvestrant in combination with Kisqali AND is pt postmenopausal

**Age Restrictions**
N/A

**Prescriber Restrictions**
Oncologist

**Coverage Duration**
Plan Year

**Other Criteria**
N/A

Updated 2/28/2020
KORLYM

Drugs
KORLYM

Covered Uses
* Cushing's Syndrome

Exclusion Criteria
Pt using long-term corticosteroid

Required Medical Information
1. Pt has previously failed surgery or chemotherapy to correct Cushing's disease OR is ineligible for surgery,
2. Pt with type II diabetes diagnosis,
3. Pt has treatment failure with at least TWO of the following:
   a. Insulin, b. metformin, c. meglitinides, d. sulfonylureas, e. thiazolidinediones, f. DPP4 inhibitors, g. GLP-1 agonists,
4. If pt is female:
   a. Pt has negative pregnancy test within past 14 days,
   b. Pt is currently using non-hormonal form of birth control

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist

Coverage Duration
Initial: 6 months,
Reauth: Plan Year

Other Criteria
N/A

Updated 2/28/2020
LENVIMA

Drugs
LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE

Covered Uses
* Hepatocellular Carcinoma (HCC)
* Renal Cell Carcinoma (RCC)
* Thyroid Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Renal cell carcinoma dx:
   a. Pt has previously been treated with anti-angiogenic therapy,
   b. Will be used in combination with everolimus,
2. Thyroid cancer dx:
   a. Tumor is refractory to treatment with radioactive iodine,
   b. Used as monotherapy
3. dx of unresectable hepatocellular carcinoma

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
N/A
LIDODERM

Drugs
LIDOCAINE 0.05 MG/MG MEDICATED PATCH

Covered Uses
* Post-Herpetic Neuralgia

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A
LONSURF

Drugs
LONSURF

Covered Uses

* Colorectal Cancer
* Gastric Cancer

Exclusion Criteria
N/A

Required Medical Information
A. Metastatic colorectal cancer
   1. Pt has previous therapy on the following:
      a. A fluoropyrimidine, b. Oxaliplatin, c. Irinotecan, d. Bevacizumab,
   2. If cancer is KRAS wild type, pt has received previous therapy with anti-EGFR therapy
B. Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
LORBRENA

Drugs
LORLATINIB 100 MG ORAL TABLET [LORBRENA], LORLATINIB 25 MG ORAL TABLET [LORBRENA]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1) Previous use of alectinib or ceritinib OR previous use of crizotinib and one other ALK inhibitor

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
12 months

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

LUCEMYRA

Drugs
LUCEMYRA

Covered Uses
* Opioid Withdrawal

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
18 years old or older

Prescriber Restrictions
Psychiatry, Addiction medicine, or Pain management

Coverage Duration
14 days

Other Criteria
N/A

Updated 2/28/2020
LUPANETA

Drugs
{1 (1 ML LEUPROLIDE ACETATE 3.75 MG/ML PREFILLED SYRINGE [LUPRON]) / 30 (NORETHINDRONE ACETATE 5 MG ORAL TABLET) } PACK [LUPANETA PACK 1-MONTH], {1 (1.5 ML LEUPROLIDE ACETATE 7.5 MG/ML PREFILLED SYRINGE [LUPRON]) / 90 (NORETHINDRONE ACETATE 5 MG ORAL TABLET) } PACK [LUPANETA PACK 3-MONTH]

Covered Uses
* Endometriosis

Exclusion Criteria
Treatment for longer than 1 year

Required Medical Information
Previous trial of leuprolide

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months
Reauth: 6 Months

Other Criteria
BvsD determination

Updated 2/28/2020
LYNPARZA

Drugs
OLAPARIB 100 MG ORAL TABLET [LYNPARZA], OLAPARIB 150 MG ORAL TABLET [LYNPARZA]

Covered Uses
* Ovarian Cancer

Exclusion Criteria
Combination therapy

Required Medical Information
1. Ovarian cancer, advanced (BRCA-mutated): Treatment of deleterious or suspected deleterious gBRCAm advanced ovarian cancer in patients who have been treated with 3 or more prior lines of chemotherapy
2. Ovarian cancer, advanced (BRCA-mutated), first-line maintenance therapy maintenance treatment of deleterious or suspected deleterious gBRCAm or somatic BRCA-mutated (sBRCAm) advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adult patients with complete or partial response to first-line platinum-based chemotherapy
3. Breast Cancer- Pt has previous trial of chemotherapy in neoadjuvant, adjuvant, or metastatic setting

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
MAVENCLAD

Drugs
MAVENCLAD

Covered Uses
* Multiple Sclerosis (MS)

Exclusion Criteria
Not covered in combination with other treatments for MS

Required Medical Information
I. Initial authorization
   A. Diagnosis of RRMS or SPMS
   B. Previous use of at least two preferred treatments
      1. Gilenya, glatiramer, Plegridy
   C. CBC within previous 6 months
   D. LFT within previous 6 months
II. Reauthorization
   A. CBC in previous 6 months
   B. Lymphocyte count at least 800 cells per microliter before initiating the second treatment course

Age Restrictions
18 years of age or older

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 2/28/2020
MAVYRET

Drugs
GLECAPREVIR 100 MG / PIBRENTASVIR 40 MG ORAL TABLET [MAVYRET]

Covered Uses
* Hepatitis C Virus (HCV)

Exclusion Criteria
N/A

Required Medical Information
Confirmation of genotype

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

Coverage Duration
16 Weeks

Other Criteria
N/A

Updated 2/28/2020
MAYZENT

Drugs
SIPONIMOD 0.25 MG ORAL TABLET [MAYZENT], SIPONIMOD 2 MG ORAL TABLET [MAYZENT]

Covered Uses
* Multiple Sclerosis (MS)

Exclusion Criteria
N/A

Required Medical Information
A. CBC and liver functions tests in the last 6 months
B. Dilated eye exam in the past 12 months
C. Tested for varicella-zoster virus
D. Testing for CYP2C9 variants for CYP2C9 genotype
E. ECG to determine if preexisting conduction abnormalities are present
F. If diagnosed with multiple sclerosis (relapsing remitting or secondary progressive)
   I. Previous use of two alternatives (Gilenya, glatiramer acetate, Plegridy)
G. If diagnosed with multiple sclerosis (clinically isolated syndrome)
   A. Previous use of glatiramer acetate

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 2/28/2020
MEKINIST

Drugs
TRAMETINIB 0.5 MG ORAL TABLET [MEKINIST], TRAMETINIB 2 MG ORAL TABLET [MEKINIST]

Covered Uses
* Malignant Melanoma

Exclusion Criteria
N/A

Required Medical Information
1. Pt is BRAF(V600E or V600K) mutation positive,
2. Monotherapy or in combination with Tafinlar

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
MIGRANAL

Drugs
DIHYDROERGOTAMINE MESYLATE

Covered Uses
* Migraine Headaches with or without Aura

Exclusion Criteria
N/A

Required Medical Information
1. Pt experiences at least 2 migraines per month,
2. Pt has trial or contraindication to at least TWO of the following:

Age Restrictions
18 years old or older

Prescriber Restrictions
Neurologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

MS

Drugs
1 ML GLATIRAMER ACETATE 20 MG/ML PREFILLED SYRINGE, 1 ML GLATIRAMER ACETATE 40 MG/ML PREFILLED SYRINGE, AVONEX, AVONEX PEN, FINGOLIMOD 0.5 MG ORAL CAPSULE [GILENYA], INTERFERON BETA-1B 0.3 MG INJECTION [EXTAVIA], PLEGRIDY, PLEGRIDY STARTER PACK, TECFIDERA, TECFIDERA STARTER PACK

Covered Uses
* Multiple Sclerosis (MS)

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

**MULPLETA**

**Drugs**
MULPLETA

**Covered Uses**
* Thrombocytopenia

**Exclusion Criteria**
N/A

**Required Medical Information**
1. Platelet count less than 50,000
2. Pt is scheduled for a procedure where there is a bleeding risk
3. Mulpleta will be used for 7 days starting 8 to 14 days prior to the procedure and discontinued 2 to 8 days prior to the procedure

**Age Restrictions**
N/A

**Prescriber Restrictions**
N/A

**Coverage Duration**
Plan Year

**Other Criteria**
N/A

Updated 2/28/2020
MYALEPT

Drugs
MYALEPT

Covered Uses
* Diabetes Mellitus

Exclusion Criteria
N/A

Required Medical Information
1. Pt has baseline leptin levels of less than 8 ng/mL for males OR less than 12 ng/mL for females,
2. Pt has ONE of the following:
   a. Diagnosis of diabetes and is being treated with Metformin AND at least one other antidiabetic agent,
   b. Diagnosis of hypertriglyceridemia and is being treated with at least ONE antihyperlipidemic agent,
3. Reauth:
   a. Pt has been screened for the presence of anti-metreleptin antibodies,
   b. If presence of anti-metreleptin antibodies, pt must still be receiving benefit from Myalept therapy,
   c. Pt shows improvement in hemoglobin A1c OR fasting triglyceride level

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist

Coverage Duration
Initial: 6 months,
Reauth: Plan Year

Other Criteria
N/A
Updated 2/28/2020
NAFCILLIN

Drugs
NAFCILLIN SODIUM

Covered Uses
* Bacterial Meningitis
* Endocarditis
* Staphylococcal Infectious Disease caused by Penicillinase-Producing Staphylococci Species

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
NATPARA

Drugs
NATPARA

Covered Uses
* Hypoparathyroidism

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist

Coverage Duration
Plan Year

Other Criteria
N/A
NERLYNX

Drugs
NERLYNX

Covered Uses
* Breast Cancer

Exclusion Criteria
1. Treatment for longer than 1 year

Required Medical Information
1. Pt has had treatment with trastuzumab within the past 2 years

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
NEXAVAR

Drugs
NEXAVAR

Covered Uses
- Hepatocellular Carcinoma (HCC)
- Renal Cell Carcinoma (RCC)
- Thyroid Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Used as monotherapy,
2. For HCC dx:
   a. Treatment for unresectable tumor or recurrent disease,
3. For Thyroid carcinoma dx:
   a. Tumor is refractory to treatment with iodine

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
NINLARO

Drugs
NINLARO

Covered Uses
* Multiple Myeloma

Exclusion Criteria
1. Pt is refractory to lenalidomide or proteasome inhibitor therapy

Required Medical Information
1. Ninlaro will be used in combination with Revlimid and dexamethasone,
2. Pt has previous trial on at least ONE other therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
NITROFURAN

Drugs
NITROFURANTOIN

Covered Uses
* Urinary Tract Infection

Exclusion Criteria
N/A

Required Medical Information
1. Unable to swallow nitrofurantoin capsules

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
NORTHERA

Drugs
NORTHERA

Covered Uses
* Neurogenic Orthostatic Hypotension

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial on BOTH of the following:
   a. Midorine, b. Fludrocortisone

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist or Neruologist

Coverage Duration
2 Weeks

Other Criteria
N/A

Updated 2/28/2020
NOURIANZ

Drugs
NOURIANZ

Covered Uses
* Parkinson's Disease

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of Parkinson's disease
2. Using 3 or more daily doses of carbidopay/levodopa
3. Previous use of two of the following:
   a. dopamine agonist (e.g. pramipexole, ropinirole) b. MAO-B inhibitor (e.g. selegiline, rasagiline) c. COMT inhibitor (e.g. entacapone)

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
NOXAFIL

Drugs
POSACONAZOLE 100 MG DELAYED RELEASE ORAL TABLET, POSACONAZOLE 40 MG/ML ORAL SUSPENSION [NOXAFIL]

Covered Uses
* Aspergillosis Prophylaxis
* Oropharyngeal Candidiasis (Thrush)

Exclusion Criteria
N/A

Required Medical Information
1. For aspergillus or candida prophylaxis:
   a. Pt is at high risk of developing infections secondary to being severely immunocompromised,
2. For oropharyngeal candidiasis:
   a. Pt has previous failure on BOTH of the following:
      1) Itraconazole, 2) Fluconazole

Age Restrictions
1. For aspergillus or candida prophylaxis: 13 years old or older

Prescriber Restrictions
N/A

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
NUBEQA

Drugs
NUBEQA

Covered Uses
* Prostate Cancer

Exclusion Criteria
N/A

Required Medical Information
A. Diagnosis of non-metastatic castration-resistant prostate cancer
B. Given in combination with GnRH analog OR has had bilateral orchiectomy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
NUDEXTA

Drugs
NUDEXTA

Covered Uses
* Pseudobulbar Affect (PBA)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has score of 13 or greater on Center for Neurologic Study-Liability Scale (CNS-LS) for pseudobulbar affect (PBA)

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
NUPLAZID

Drugs
NUPLAZID

Covered Uses
* Parkinson's Disease Psychosis with Hallucinations/Delusions

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Onset of psychosis took place after the diagnosis of Parkinson's disease,
   b. Pt has previous trial on treatment with clozapine or quetiapine,
2. Reauth:
   a. Pt experienced a decrease in psychosis related symptoms while on treatment

Age Restrictions
N/A

Prescriber Restrictions
Neurologist or Psychiatrist

Coverage Duration
Initial: 3 months,
Reauth: 12 months

Other Criteria
N/A

Updated 2/28/2020
OCALIVA

Drugs
OCALIVA

Covered Uses
* Primary Biliary Cholangitis (PBC)

Exclusion Criteria
1. Pt does not have clinically significant complications of PBC

Required Medical Information
1. Initial:
   a. Dx of PBC is confirmed by at least TWO of the following:
      i. Elevated mean alkaline phosphatase (ALP) levels of at least 1.5 times the upper limit of normal (ULN) from at least two consecutive readings separated by at least one month (more than 175 U/L for women and 195 U/L for men),
      ii. Positive for antimitochondrial antibody (AMA) titer (greater than 1:40 titer on immunofluorescence or M2 positive by enzyme-linked imunoabsorbant assay) or PBC-specific antinuclear antibodies,
      iii. Liver biopsy showing histological evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts),
   b. Pt has trial on ursodiol,
   c. Ocaliva will be taken in combination with ursodiol,
   d. Pt has ALP at least 1.67 times the upper limit of normal (ULN) (At least 197 U/L for females and 207 U/L for males),
   e. Pt has a total bilirubin greater than the ULN, but less than 2 times the ULN (value between 1.1 - 2.2 mg/dL for females and 1.5 - 3 mg/dL for males),
2. Reauth:
   a. Pt has acheived an ALP less than 1.67 times the ULN,
   b. Pt had an ALP decrease of at least 15% compared to baseline,
   c. Pt's current total bilirubin is within normal limits

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist or Transplant Specialist
Updated 2/28/2020
Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
OCTREOTIDE

Drugs
1 ML OCTREOTIDE 0.05 MG/ML INJECTION, OCTREOTIDE 0.2 MG/ML INJECTABLE SOLUTION, OCTREOTIDE ACETATE

Covered Uses
* Acromegaly
* Carcinoid
* Gastroenteropancreatic Neuroendocrine Tumor
* Vasoactive Intestinal Peptide Secreting Tumors (VIPomas)

Exclusion Criteria
N/A

Required Medical Information
1. For acromegaly:
   a. Has patient failed at least TWO of the following:
      i. Surgical resection,
      ii. Pituitary irradiation,
      iii. Bromocriptine,
   b. Pt has elevated levels of growth hormone and IGF-1,
2. For carcinoid:
   a. Pt is suffering from severe diarrhea and flushing episodes associated with disease,
3. For VIPoma:
   a. Pt has profuse water diarrhea associated with disease

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, Oncologist, or Gastroenterologist

Updated 2/28/2020
Covered Duration
1. For acromegaly: 6 mo,
2. For others: Plan year

Other Criteria
BvsD determination

Updated 2/28/2020
OLUMIANT

Drugs
BARICITINIB 1 MG ORAL TABLET [OLUMIANT], BARICITINIB 2 MG ORAL TABLET [OLUMIANT]

Covered Uses
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has persistent active disease and been treated for at least 3 months
2. Pt has previous trial on at least TWO of:
   - Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
18 yo or older

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ONFI

Drugs
CLOBAZAM, SYMPAZAN

Covered Uses
* Lennox-Gastaut Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trail on at least TWO AED medications

Age Restrictions
N/A

Prescriber Restrictions
Neurologist OR
For non-Lennox-Gastaut indications: Epileptologist

Coverage Duration
Plan Year

Other Criteria
N/A
ORENCIA

Drugs
0.4 ML ABATACEPT 125 MG/ML PREFILLED SYRINGE [ORENCIA], 0.7 ML ABATACEPT 125 MG/ML PREFILLED SYRINGE [ORENCIA], 1 ML ABATACEPT 125 MG/ML AUTO-INJECTOR [ORENCIA], 1 ML ABATACEPT 125 MG/ML PREFILLED SYRINGE [ORENCIA]

Covered Uses
* Polyarticular Juvenile Idiopathic Arthritis (JIA)
* Rheumatoid Arthritis (RA)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial on TWO of:
   - Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ORFADIN

Drugs
NITYR, ORFADIN

Covered Uses
* Hereditary Tyrosinemia Type 1 (HT-1)

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Diagnosis is confirmed by biochemical or DNA testing
   b. Pt had a baseline succinylacetone (SA) level drawn
   c. Pt had a baseline liver function testing performed
2. Reauthorization:
   a. There is laboratory documentation of SA suppression on treatment when compared to baseline level

Age Restrictions
N/A

Prescriber Restrictions
Medical Geneticist or Metabolic Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ORILISSA

Drugs
ELAGOLIX 150 MG ORAL TABLET [ORILISSA], ELAGOLIX 200 MG ORAL TABLET [ORILISSA]

Covered Uses
* Endometriosis

Exclusion Criteria
N/A

Required Medical Information
1) previous use of combination oral contraceptive 2) previous use of progestin-only contraceptive

Age Restrictions
N/A

Prescriber Restrictions
Obstetrician gynecologist

Coverage Duration
12 months for Orilissa 150 mg
6 months for Orilissa 200 mg

Other Criteria
N/A

Updated 2/28/2020
ORKAMBI

Drugs
ORKAMBI

Covered Uses
* Cystic Fibrosis

Exclusion Criteria
Pt has history of solid organ transplant

Required Medical Information
1. Initial:
   a. Pt has cystic fibrosis with the homozygous F508del mutation in the CTFR gene that has been confirmed by an FDA approved test,
   b. If pt has been previously colonized with an organism associated with rapid decline in pulmonary function:
      1) Pt has had 2 negative respiratory tract cultures for the organism with in the last 12 months
2. Reauth:
   a. Pt has been reassessed since starting therapy,
   b. Pt's FEV1 has increased since starting therapy

Age Restrictions
2 yo and older

Prescriber Restrictions
Pulmonologist or midlevel provider in a clinic that specializes in the treatment of cystic fibrosis

Coverage Duration
Initial: 3 Months,
Reauth: 12 Months

Other Criteria
BvsD Determination

Updated 2/28/2020
OTEZLA

Drugs
OTEZLA

Covered Uses
* Plaque Psoriasis
* Psoriatic Arthritis (PsA)

Exclusion Criteria
N/A

Required Medical Information
1. For Psoriasis or psoriatic arthritis, previous trial on TWO of:
   Cimzia, Enbrel, Entyvio, Humira, Renflexis, Skyrizi, Cosentyx
2. For Behcet disease, previous trial on:
   Humira, Renflexis

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

**PAH**

**Drugs**
SILDENAFIL CITRATE, TADALAFIL

**Covered Uses**
* Pulmonary Arterial Hypertension (PAH)

**Exclusion Criteria**
N/A

**Required Medical Information**
1. Initial:
   a. PAPm greater than or equal to 25 mmHG AND PCWP less than or equal to 15 mmHG,
   b. Pt with positive vasoreactivity test:
      i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers,
2. Reauth:
   a. Pt has been reassess within the past 6 months

**Age Restrictions**
N/A

**Prescriber Restrictions**
Pulmonologist or Cardiologist

**Coverage Duration**
Plan Year

**Other Criteria**
1. Tadalafil requests: previous trial on sildenafil

Updated 2/28/2020
PALYNZIQ

Drugs
PALYNZIQ

Covered Uses
* Hyperphenylalaninemia
* Phenylketonuria (PKU)

Exclusion Criteria
N/A

Required Medical Information
1. If PKU dx: Pt has trial on Kuvan therapy
2. All dx: Pt has a blood phenylalanine (Phe) concentration of greater than 600 micromol/L

Age Restrictions
N/A

Prescriber Restrictions
Medical Geneticist or consult

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
PANRETIN

Covered Uses
* AIDs-Related Kaposi's Sarcoma (KS)

Exclusion Criteria
1. Pt does not have more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement

Required Medical Information
1. Initial:
   a. Panretin will not be used in combination with a systemic anti-KS therapy,
2. Reauth:
   a. Pt has derived benefit from use of Panretin

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
PHENOXYBENZAMINE

Drugs
PHENOXYBENZAMINE HYDROCHL

Covered Uses
* Pheochromocytoma

Exclusion Criteria
N/A

Required Medical Information
1. Phenoxybenzamine will be used for short-term treatment of hypertension prior to surgical removal of a pheochromocytoma

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
3 mo

Other Criteria
N/A

Updated 2/28/2020
PIQRAY

Drugs
{28 (ALPELISIB 200 MG ORAL TABLET [PIQRAY]) / 28 (ALPELISIB 50 MG ORAL TABLET [PIQRAY]) } PACK [PIQRAY 250 MG DAILY DOSE], {28 (ALPELISIB 200 MG ORAL TABLET [PIQRAY]) } PACK [PIQRAY 200 MG DAILY DOSE], {56 (ALPELISIB 150 MG ORAL TABLET [PIQRAY]) } PACK [PIQRAY 300 MG DAILY DOSE]

Covered Uses
* Breast Cancer

Exclusion Criteria
Premenopausal female

Required Medical Information
A. Postmenopausal female or male
B. Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer
C. PIK3CA-mutation positive
D. Receiving or previous use of an aromatase inhibitor
E. Disease progression after endocrine-based regimen
F. Use in combination with fulvestrant

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
POMALYST

Drugs
POMALYST

Covered Uses
* Multiple Myeloma

Exclusion Criteria
N/A

Required Medical Information
1. Pt has tried BOTH of the following:
   a. Revlimid, b. Velcade,
2. Pt has demonstrated disease progression within 60 days of completion of prior therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
Covered Uses
- Osteoporosis Prophylaxis for Postmenopausal Women
- Vasomotor Symptoms associated with Menopause
- Vulvar and Vaginal Atrophy associated with Menopause

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A
PREVYMIS

Drugs
LETERMOVIR 240 MG ORAL TABLET [PREVYMIS], LETERMOVIR 480 MG ORAL TABLET [PREVYMIS]

Covered Uses
* Prevention of Cytomegalovirus Infection

Exclusion Criteria
Pt has Child-Pugh class C hepatic impairment

Required Medical Information
1. Pt is post allogenic hematopoietic stem cell transplant within the last 28 days
2. Pt is a CMV-seropositive recipient [R+]
3. Medication will be discontinued on or before 100 days post-transplantation

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, Transplant Specialist, or Infectious Disease Specialist

Coverage Duration
100 days

Other Criteria
BvsD Determination

Updated 2/28/2020
PRIMAXIN

Drugs
IMIPENEM/CILASTATIN

Covered Uses

* Bacterial Septicemia
* Bone and Joint Infection
* Gynecologic Infection
* Intra-Abdominal Infection
* Lower Respiratory Tract Infection
* Polymicrobial Infection
* Skin and Skin Structure Infection
* Urinary Tract Infection

Exclusion Criteria

1. Pt has had a positive culture within the past month indicating a MRSA infection

Required Medical Information

1. For infections of the lower respiratory tract, urinary tract, intra-abdominal, gynecologic, bone and joint, skin and skin structure, polymicrobial infections, or bacterial septicemia:
   a. Pt has had a positive culture within the past month for ANY of the following:
      i. Staphylococcus aureus (MSSA),
      ii. Streptococcus spp.,
      iii. Escherichia coli,
      iv. Klebsiella spp.,
      v. Enterobacter,
      vi. Pseudomonas aeruginosa,
      vii. Other resistant gram-negative bacilli,
      vii. Other anaerobes,
   2. Pt must meet ONE of the following:
      a. Pt has a CrCl greater than or equal to 5 mL/minute/1.73 m2,
      b. Pt will be on hemodialysis within 48 hours of therapy,

Updated 2/28/2020
3. Pt has failed at least ONE previous antibacterial and/or other antimicrobial therapy

**Age Restrictions**
N/A

**Prescriber Restrictions**
Infectious Disease Specialist

**Coverage Duration**
1 Month

**Other Criteria**
BvsD determination
PROMACTA

Drugs
ELTROMBOPAG 12.5 MG ORAL TABLET [PROMACTA], ELTROMBOPAG 12.5 MG POWDER FOR ORAL SUSPENSION [PROMACTA], ELTROMBOPAG 25 MG ORAL TABLET [PROMACTA], ELTROMBOPAG 50 MG ORAL TABLET [PROMACTA], ELTROMBOPAG 75 MG ORAL TABLET [PROMACTA]

Covered Uses
* Aplastic Anemia
* Chronic Immune (Idiopathic) Thrombocytopenic Purpura (ITP)
* Thrombocytopenia

Exclusion Criteria
N/A

Required Medical Information
1. For ITP dx:
   a. Previous failure to corticosteroids, immunoglobulins, OR splenectomy,
   b. Initial: Evidence of bleeding OR platelet count less than 50,000/microL,
   c. For Reauth: Platelet count less than 400,000/microL,
2. For Hep C with Thrombocytopenia dx:
   a. Platelet count less than 75,000/microL,
3. For aplastic anemia dx:
   a. Pt has an insufficient response to immunosuppressive therapy
   b. In combination with immunosuppressive therapy for severe aplastic anemia

Age Restrictions
N/A

Prescriber Restrictions
For ITP: Oncologist or Hematologist

Coverage Duration
6 Months
Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

Other Criteria
N/A
PROTEINASE INHIBITOR

Drugs
ALPHA 1-PROTEINASE INHIBITOR, HUMAN 1 MG INJECTION [ARALAST], ALPHA 1-PROTEINASE INHIBITOR, HUMAN 1 MG INJECTION [GLASSIA], ALPHA 1-PROTEINASE INHIBITOR, HUMAN 1 MG INJECTION [ZEMAIRA], PROLASTIN-C

Covered Uses
* Alpha-1 Antitrypsin Deficiency
* Chronic Obstructive Pulmonary Disease (COPD)

Exclusion Criteria
N/A

Required Medical Information
1. If request for medication other than Prolastin: Trial and failure or intolerance to Prolastin,
2. Pt has serum alpha-1 antitrypsin less than 11 micromoles,
3. Pt has either PiZZ or PiSZ genotype,
4. If the request is for Zemaira, does the patient have the m-malton genotype

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist specializing in treatment of Alpha-1 antitrypsin deficiency or COPD

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
PULMONARY FIBROSIS

Drugs
ESBRIET, NINTEDANIB 100 MG ORAL CAPSULE [OFEV], NINTEDANIB 150 MG ORAL CAPSULE [OFEV]

Covered Uses
* Idiopathic Pulmonary Fibrosis (IPF)

Exclusion Criteria
For Ofev: Pt is receiving anticoagulation therapy

Required Medical Information
1. Initial:
   a. All other causes of ILD have been eliminated,
   b. Diagnosis has been confirmed via high-resolution computed tomography scan and/or lung biopsy,
   c. Pt Forced Vital Capacity (FVC) is greater than or equal to 50% predicted value,
   d. Pt carbon monoxide diffusing capacity is greater than or equal to 30% predicted value,
   e. Liver function test has been completed prior to initiating therapy,
2. Reauth:
   a. A repeat liver function test has been performed after 3 months of therapy has been completed

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist

Coverage Duration
Initial: 3 mo,
Reauth: 1 year

Other Criteria
N/A
Updated 2/28/2020
PURIXAN

Drugs
PURIXAN

Covered Uses
* Acute Lymphocytic Leukemia (ALL)

Exclusion Criteria
N/A

Required Medical Information
1. Used in conjunction with a combination chemotherapy treatment regimen for ALL,
2. Pt has previous failure on mercaptopurine tablets

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
RCC

Drugs
EVEROLIMUS, EVEROLIMUS 10 MG ORAL TABLET [AFINITOR], EVEROLIMUS 2 MG TABLET FOR ORAL SUSPENSION [AFINITOR], EVEROLIMUS 3 MG TABLET FOR ORAL SUSPENSION [AFINITOR], EVEROLIMUS 5 MG TABLET FOR ORAL SUSPENSION [AFINITOR]

Covered Uses
* Breast Cancer
* Progressive Neuroendocrine Tumors (PNET) of Pancreatic Origin
* Renal Angiomyolipoma with Tuberous Sclerosis Complex (TSC)
* Renal Cell Carcinoma (RCC)
* Subependymal Giant Cell Astrocytoma (SEGA) associated with Tuberous Sclerosis (TS)

Exclusion Criteria
For renal angiomyolipoma, requires immediate surgery

Required Medical Information
1. For RCC dx:
   a. Previous failure on either Sutent or Nexavar,
2. For SEGA or TS dx:
   a. Patient must require therapeutic intervention and not be a candidate for surgical resection
3. Diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) or with well-differentiated, nonfunctional neuroendocrine tumors (NET) of gastrointestinal (GI), or lung origin which are unresectable, locally advanced or metastatic
4. Diagnosed with renal angiomyolipoma with tuberous sclerosis complex with at least one angiomyolipoma less than or equal to 3cm where there is not an immediate need for surgery
5. Hormone receptor positive HER2-negative breast cancer
   a. Previous use of one of letrozole or anastrozole
   b. Use in combination with one of exemastane, tamoxifen, or fulvestrant

Age Restrictions
N/A

Prescriber Restrictions
N/A

Updated 2/28/2020
## Coverage Duration
Plan Year

## Other Criteria
N/A
RELISTOR

Drugs
RELISTOR

Covered Uses
* Opiate Agonist-Induced Constipation

Exclusion Criteria
N/A

Required Medical Information
1. Pt has advanced illness, OR
2. For OIC in chronic non-cancer pain dx:
   a. Pt has been on opioid therapy for a month or more,
3. Pt has tried at least TWO of the following:
   a. Symproic, b. Movantik, c. Amitiza
4. For Relistor injection: Pt is unable to take oral Relistor

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

REPATHA

Drugs
PRALUENT, REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

Covered Uses
* Clinical Atherosclerotic Cardiovascular Disease (ASCVD)

Exclusion Criteria
N/A

Required Medical Information
1. Dx with HoFH
2. For a dx of HeFH or dx of ASCVD:
   A. Used in combination with maximally tolerated statin OR documented statin intolerance,
   B. Previous failure on TWO lipid lowering therapies that consist of a maximally tolerated statin,
   C. LDL greater than 100 mg/dl despite treatment with maximally tolerated treatment regimens,
   D. For a diagnosis of ASCVD (e.g. MI, stroke, TIA, persistent intermittent claudication, coronary intervention revascularization, angina with proven ischemia):
      a. is there a history of one of: i. acute coronary syndrome in the past year, ii. diabetes mellitus, iii. CKD (stage 3-5), iv. recurrent cardiovascular disease event or need for revascularization while on statin therapy, v. Polyvascular disease
      b. Pt's LDL is greater than 70 mg/dl

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist, Endocrinologist, Or Other Specialist in Lipid Disorders

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
N/A
RESTASIS

Drugs
CYCLOSPORINE 0.5 MG/ML OPHTHALMIC SUSPENSION [RESTASIS]

Covered Uses
  * Xerophthalmia

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Ophthalmologist or Optometrist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
REVLIMID

Drugs
REVLIMID

Covered Uses
- Mantle Cell Lymphoma (MCL)
- Multiple Myeloma
- Myelodysplastic Syndrome (MDS)

Exclusion Criteria
N/A

Required Medical Information
1. For Multiple Myeloma dx:
   a. Used in combination with dexamethasone,
2. For MCL:
   a. Pt has previous trial on bortezomib AND pt has trial on at least ONE other previous therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
RINVOQ

Drugs
24 HR UPADACITINIB 15 MG EXTENDED RELEASE ORAL TABLET [RINVOQ]

Covered Uses
* Rheumatoid Arthritis (RA)

Exclusion Criteria
A. Combination therapy with another biologic medication, JAK inhibitor or Otezla

Required Medical Information
A. Diagnosis of moderate to severe active rheumatoid arthritis
B. Pt has failed at least three months therapy on at least ONE of the following:
   1. methotrexate, ii. leflunomide, iii. hydroxychloroquine, iv. sulfasalazine, v. injectable gold, vi. oral gold, vii. azathioprine, viii. penicillamine, ix. cyclosporine,

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ROZLYTREK

Drugs
ROZLYTREK

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of non-small cell lung cancer
   A. Has reactive oxygen species 1 positive
2. Diagnosis of Neurotrophic receptor tyrosine kinase-positive solid tumors
   A. Tumor is metastatic or surgical resection likely to result in severe morbidity
   B. Progression following previous treatment or there is not an adequate alternative treatment

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
RUBRACA

Drugs
RUBRACA

Covered Uses
* Ovarian Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Dx of BRCA-mutated ovarian cancer
   a. Pt has been treated with at least two prior chemotherapies,
2. Dx of recurrent ovarian cancer
   a. Complete or partial response to platinum-based chemotherapy
3. Rubraca will be used as monotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
RYDAPT

Drugs
MIDOSTAURIN 25 MG ORAL CAPSULE [RYDAPT]

Covered Uses
* Acute Myelogenous Leukemia (AML)
* Systemic Mastocytosis (SM)

Exclusion Criteria
1. Rydapt is being used for post-consolidation therapy

Required Medical Information
1. For AML dx:
   a. Cancer is FLT3 mutation positive

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SABRIL

Drugs
VIGABATRIN, VIGABATRIN 500 MG ORAL TABLET, VIGABATRIN 500 MG POWDER FOR ORAL SOLUTION [VIGADRONE]

Covered Uses
* Infantile Spasms
* Refractory Complex Partial Seizures

Exclusion Criteria
N/A

Required Medical Information
1. For solution:
   a. Must be used as monotherapy for infantile spasms,
2. For tablets:
   a. Must be used as adjunctive therapy,
   b. Must have tried at least TWO of the following:

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
1. Periodic vision testing

Updated 2/28/2020
SENSIPAR

Drugs
CINACALCET 30 MG ORAL TABLET, CINACALCET 60 MG ORAL TABLET, CINACALCET 90 MG ORAL TABLET

Covered Uses
* Hypercalcemia associated with Hyperparathyroidism (HPT)
* Hypercalcemia associated with Parathyroid Carcinoma (PC)
* Secondary Hyperparathyroidism (HPT) with Chronic Kidney Disease (CKD)

Exclusion Criteria
N/A

Required Medical Information
1. Hypercalcemia associated with HPT dx:
   a. Pt is NOT a candidate for parathyroidectomy

Age Restrictions
18 years old or older

Prescriber Restrictions
Nephrologist, Oncologist, or Endocrinologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SIGNIFOR

Drugs
1 ML PASIREOTIDE 0.3 MG/ML INJECTION [SIGNIFOR], 1 ML PASIREOTIDE 0.6 MG/ML INJECTION [SIGNIFOR], 1 ML PASIREOTIDE 0.9 MG/ML INJECTION [SIGNIFOR]

Covered Uses
* Cushing’s Syndrome

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt is NOT a candidate for pituitary surgery,
   b. If pt previously had pituitary surgery: Pt continues to have 24-hour urinary free crotisol levels of:
      i. 90 micrograms or greater if male,
      ii. 67 micrograms or greater if female

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist

Coverage Duration
Initial: 3 mo,
Reauth: Plan Year

Other Criteria
N/A

Updated 2/28/2020
SIRTURO

Drugs
SIRTURO

Covered Uses
* Tuberculosis

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous failure on at least TWO of the following:

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Infectious Disease Specialist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
SITAVIG

Drugs
SITAVIG

Covered Uses
* Herpes Labialis

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of recurrent herpes labialis
2. Patient is immunocompetent
3. Previous treatment with two generic oral antiviral therapies (acyclovir, famciclovir, valacyclovir)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SKYRIZI

Drugs
{2 (0.83 ML RISANKIZUMAB-RZAA 90.4 MG/ML PREFILLED SYRINGE [SKYRIZI]) } PACK [SKYRIZI 150 MG DOSE PACK]

Covered Uses
* Plaque Psoriasis

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of plaque psoriasis

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SPRYCEL

Drugs
DASATINIB 100 MG ORAL TABLET [SPRYCEL], DASATINIB 140 MG ORAL TABLET [SPRYCEL], DASATINIB 20 MG ORAL TABLET [SPRYCEL], DASATINIB 50 MG ORAL TABLET [SPRYCEL], DASATINIB 70 MG ORAL TABLET [SPRYCEL], DASATINIB 80 MG ORAL TABLET [SPRYCEL]

Covered Uses
* Acute Lymphocytic Leukemia (ALL)
* Chronic Myelogenous Leukemia (CML)

Exclusion Criteria
N/A

Required Medical Information
1. For chronic, accelerated, myeloid, or blast phase CML dx:
   a. Previous trial on imatinib,
2. For ALL dx:
   a. Resistance or intolerance to at least ONE prior therapy,
   b. Efficacy testing will be conducted in accordance with NCCN recommended treatment guidelines,
   c. After failure of treatment per NCCN CML guideline testing patient does NOT have a T315I mutation based BCR-ABL kinase domain testing

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
STELARA

Drugs
STELARA

Covered Uses
* Crohn's Disease
* Plaque Psoriasis
* Psoriatic Arthritis (PsA)
* Ulcerative Colitis (UC)

Exclusion Criteria
1. Treatment initiation during an active infection

Required Medical Information
1. For PSA dx previous trial on TWO:
   a. Orencia
   b. Otezla
2. For Crohn's dx previous trial on TWO
   a. Cimzia
   b. Humira
   c. Entyvio
   d. Renflexis
3. For psoriasis dx previous trial on TWO:
   a. Ilumya
   b. Otezla
   c. Otezla

Age Restrictions
N/A

Prescriber Restrictions
1. Plaque psoriasis dx: Dermatologist or consult,

Updated 2/28/2020
2. Crohn's or UC disease dx: Gastroenterologist or consult
3. Psoriatic arthritis dx: Dermatologist, Rheumatologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A
STIVARGA

Drugs
STIVARGA

Covered Uses
* Colorectal Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Dx metastatic colorectal cancer,
2. Dx gastrointestinal stromal tumor,
3. Dx hepatocellular carcinoma

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SUCRAID

Drugs
SUCRAID

Covered Uses
* Congenital Sucrase-Isomaltase Deficiency

Exclusion Criteria
N/A

Required Medical Information
1. Dx is confirmed by a Small Bowel Biopsy Disaccharidase Measurement demonstrating 2 SD or more below mean for sucrase activity with or without isomaltase activity

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist or Metabolic Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SUTENT

Drugs
SUNITINIB 12.5 MG ORAL CAPSULE [SUTENT], SUNITINIB 25 MG ORAL CAPSULE [SUTENT], SUNITINIB 37.5 MG ORAL CAPSULE [SUTENT], SUNITINIB 50 MG ORAL CAPSULE [SUTENT]

Covered Uses
* Gastrointestinal Stromal Tumor
* Pancreatic Neuroendocrine Tumors (pNET)
* Renal Cell Carcinoma (RCC)

Exclusion Criteria
1. Sutent used as combination therapy with other chemotherapies

Required Medical Information
1. For GIST dx:
   a. Disease progression or intolerance to Gleevec,
2. For pNET dx:
   a. Tumor is unresectable locally advanced or metastatic

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SYLATRON

Drugs
PEGINTERFERON ALFA-2B 0.2 MG INJECTION [SYLATRON], PEGINTERFERON ALFA-2B 0.3 MG INJECTION [SYLATRON], PEGINTERFERON ALFA-2B 0.6 MG INJECTION [SYLATRON]

Covered Uses
* Malignant Melanoma

Exclusion Criteria
N/A

Required Medical Information
1. Pt has stage III melanoma with previous surgical resection,
2. Surgical resection (including lymphadenectomy) were less than 84 days prior to request

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SYMDEKO

Drugs
SYMDEKO

Covered Uses
* Cystic Fibrosis

Exclusion Criteria
Pt has history of a transplant

Required Medical Information
1. Initial:
   a. Pt has been genotyped by a FDA-approved CF mutation test and the mutation is responsive to Symdeko
   b. If pt has been previously colonized with rapid decline in pulmonary function, then pt must have had 2 negative respiratory cultures within the past 12 months
2. Reauthorization:
   a. Pt has been reassessed
   b. Pt's FEV1 has increased since initiation of Symdeko

Age Restrictions
6 yo and older

Prescriber Restrictions
Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

SYNAREL

Drugs
NAFARELIN 0.2 MG/ACTUAT METERED DOSE NASAL SPRAY [SYNAREL]

Covered Uses
* Central Precocious Puberty
* Endometriosis

Exclusion Criteria
N/A

Required Medical Information
Pt has previous trial on leuprolide acetate

Age Restrictions
1. For CPP: Treatment initiated at or before 8 years of age in girls and 9 years of age in boys
2. For Endometriosis: 18 years old or older

Prescriber Restrictions
Endocrinologist or Gynecologist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
SYNRIBO

Drugs
SYNRIBO

Covered Uses
* Chronic Myelogenous Leukemia (CML)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has resistance and/or intolerance to TWO or more of the following:
   a. Gleevec, b. Sprycel, c. Tasigna, d. Bosulif

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
SYPRINE

Drugs
TRIENTINE HYDROCHLORIDE 250 MG ORAL CAPSULE

Covered Uses
* Wilson Disease

Exclusion Criteria
N/A

Required Medical Information
1. Pt has failure on Depen,
2. Pt is receiving oral zinc salts

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TAFINLAR

Drugs
DABRAFENIB 50 MG ORAL CAPSULE [TAFINLAR], DABRAFENIB 75 MG ORAL CAPSULE [TAFINLAR]

Covered Uses
* Malignant Melanoma
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
1. Previous use of Tafinlar, Mekinist, Keytruda, or Opdivo

Required Medical Information
1. For Melanoma dx: Pt is BRAF (V600E or V600K) mutation positive
2. For NSCLC dx: Pt is BRAF V600E positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TAGRISSO

Drugs
OSIMERTINIB 40 MG ORAL TABLET [TAGRISSO], OSIMERTINIB 80 MG ORAL TABLET [TAGRISSO]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
N/A

Required Medical Information
1. Pt is positive for EGFR T790M mutation,
   a. Pt has previous therapy after EGFR TKI therapy
2. Epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TALZENNA

Drugs
TALAZOPARIB 0.25 MG ORAL CAPSULE [TALZENNA], TALAZOPARIB 1 MG ORAL CAPSULE [TALZENNA]

Covered Uses
* Breast Cancer

Exclusion Criteria
N/A

Required Medical Information
1) Deleterious or suspected deleterious germline BRCA, HER2-negative locally advanced or metastatic breast cancer
2) prior treatment with a taxane and/or anthracycline in the neoadjuvant, adjuvant, locally advanced, or metastatic setting

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan year

Other Criteria
N/A

Updated 2/28/2020
TARCEVA

Drugs
ERLOTINIB 100 MG ORAL TABLET, ERLOTINIB 150 MG ORAL TABLET, ERLOTINIB 25 MG ORAL TABLET

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)
* Pancreatic Cancer

Exclusion Criteria
N/A

Required Medical Information
1. For NSCLC dx:
   a. Pt with EGFR mutation,
   b. Erlotinib is not used in combination with platinum-based chemotherapy,
2. For pancreatic cancer dx:
   a. Combination with gemcitabine

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TARGRETIN

Drugs
BEXAROTENE, BEXAROTENE 0.01 MG/MG TOPICAL GEL [TARGRETIN]

Covered Uses
* Cutaneous T-Cell Lymphoma (CTCL)

Exclusion Criteria
1. If female: Pt planning to become pregnant

Required Medical Information
1. Capsules:
   a. Pt has previous failure on at least ONE of the following:
      i. Antineoplastic chemotherapy, ii. Interferon alfa and gamma, iii. Interleuking-12, iv. Interleukin-2,
2. Gel:
   a. Pt has previous failure on at least ONE of the following:

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist, Hematologist, or Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TASIGNA

Drugs
NILOTINIB 150 MG ORAL CAPSULE [TASIGNA], NILOTINIB 200 MG ORAL CAPSULE [TASIGNA], NILOTINIB 50 MG ORAL CAPSULE [TASIGNA]

Covered Uses
* Chronic Myelogenous Leukemia (CML)

Exclusion Criteria
N/A

Required Medical Information
1. Documented resistance or intolerance to gleevec for chronic phase or accelerated phase CML

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TAVALISSE

Drugs
TAVALISSE

Covered Uses
* Thrombocytopenia

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt has previous trial on previous therapy of at least ONE of the following:
      i. Corticosteroids
      ii. Immunoglobulins
      iii. Splenectomy
      iv. Thrombopoietin Receptor Agonist
   b. Platelet count is less than 50000/microL
2. Reauth:
   a. Platelet count is greater than 50000/microL

Age Restrictions
N/A

Prescriber Restrictions
Hematologist, Oncologist

Coverage Duration
Initial: 3 Months
Reauth: Plan Year

Updated 2/28/2020
Other Criteria
N/A

Updated 2/28/2020
TEFLARO

Drugs
CEFTAROLINE FOSAMIL 400 MG INJECTION [TEFLARO], CEFTAROLINE FOSAMIL 600 MG INJECTION [TEFLARO]

Covered Uses
* Community-Aquired Pneumonia
* Skin and Skin Structure Infection

Exclusion Criteria
N/A

Required Medical Information
1. For acute bacterial skin and skin structure infections:
   a. Pt has had a positive culture within the past month for ANY of the following:
      i. Staphylococcus aureus (MSSA and MRSA),
      ii. Streptococcus pyogenes,
      iii. Streptococcus agalactiae,
      iv. Escherichia coli,
      v. Klebsiella pneumonia,
      vi. Klebsiella oxytoca,
2. For community-acquired bacterial pneumonia:
   a. Pt has had a positive culture within the past month for ANY of the following:
      i. Staphylococcus aureus (MSSA only),
      ii. Streptococcus pneumoniae,
      iii. Haemophilus influenzae,
      iv. Escherichia coli,
      v. Klebsiella pneumonia,
      vi. Klebsiella oxytoca

Age Restrictions
N/A

Updated 2/28/2020
Prescriber Restrictions
Infectious Disease Specialist

Coverage Duration
1 Month

Other Criteria
BvsD determination
TEGSEDI

Drugs
TEGSEDI

Covered Uses
* Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR Amyloidosis)

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt has applicable mutation to the TTR gene (V30M or V122I)
   b. Pt has objective evidence of neuropathy based on bedside exam, nerve conduction studies, skin biopsy, and/or autonomic testing
   c. Pt will have baseline and biweekly platelet counts and renal function labs
2. Reauth:
   a. Pt has experience a clinical stabilization or improvement of neurologic impairment, motor function, cardiac function, and/or serum TTR levels

Age Restrictions
18 years old or older

Prescriber Restrictions
Provider that specializes in treatment of hTTAR amyloidosis

Coverage Duration
Initial: 6 months
Reauth: 6 months

Other Criteria
BvsD Determination

Updated 2/28/2020
TEMAZEPAM

Drugs
TEMAZEPAM, TEMAZEPAM 7.5 MG ORAL CAPSULE

Covered Uses
* Sleep Disorders

Exclusion Criteria
N/A

Required Medical Information
Pt has trial and failure on at least TWO of the following:

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
THIORIDAZINE

Drugs
THIORIDAZINE 10 MG ORAL TABLET, THIORIDAZINE 100 MG ORAL TABLET, THIORIDAZINE 25 MG ORAL TABLET, THIORIDAZINE 50 MG ORAL TABLET

Covered Uses
* Schizophrenia

Exclusion Criteria
N/A

Required Medical Information
1. Previous trial on BOTH of the following:
   a. Fluphenazine, b. Molindone

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A
TIBSOVO

Drugs
TIBSOVO

Covered Uses
* Acute Myelogenous Leukemia (AML)

Exclusion Criteria
N/A

Required Medical Information
1. AML newly diagnosed is susceptible isocitrate dehydrogenase-1 (IDH1) mutation
2. AML is susceptible isocitrate dehydrogenase-1 (IDH1) mutation and has relapsed or is refractory to one or more prior anticancer regimens

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
12 months

Other Criteria
N/A

Updated 2/28/2020
TRIKAFTA

Drugs
TRIKAFTA

Covered Uses
* Cystic Fibrosis

Exclusion Criteria
1. Pt has history of a transplant
2. Clinically significant cirrhosis

Required Medical Information
1. Initial:
   a. Pt has been genotyped by a FDA-approved CF mutation test and the mutation is responsive to Trikafta
   b. If pt has been previously colonized with rapid decline in pulmonary function, then pt must have had 2 negative respiratory cultures within the past 12 months
2. Reauthorization:
   a. Pt has been reassessed b. Pt's FEV1 has increased since initiation of Trikafta

Age Restrictions
12 yo and older

Prescriber Restrictions
Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TROKENDI

Drugs
SPRINKLE 24 HR TOPIRAMATE 100 MG EXTENDED RELEASE ORAL CAPSULE, SPRINKLE 24 HR TOPIRAMATE 150 MG EXTENDED RELEASE ORAL CAPSULE, SPRINKLE 24 HR TOPIRAMATE 200 MG EXTENDED RELEASE ORAL CAPSULE, SPRINKLE 24 HR TOPIRAMATE 25 MG EXTENDED RELEASE ORAL CAPSULE, SPRINKLE 24 HR TOPIRAMATE 50 MG EXTENDED RELEASE ORAL CAPSULE

Covered Uses
* Lennox-Gastaut Syndrome
* Migraine
* Partial Onset Seizures
* Tonic-Clonic Seizures

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous failure on immediate release topiramate,
2. Pt has previous failure with at least ONE other antiepileptic drug

Age Restrictions
1. Topiramate ER: 2 years old and older

Prescriber Restrictions
Neurologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TURALIO

Drugs
TURALIO

Covered Uses

* Tenosynovial Giant Cell Tumor

Exclusion Criteria
N/A

Required Medical Information
A. Diagnosis of Tenosynovial Giant Cell Tumor
B. Condition is associated with severe morbidity or functional limitations
C. Surgery will NOT improve status

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or orthopedic surgeon

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TYGACIL

Drugs
TIGECYCLINE 50 MG INJECTION

Covered Uses
* Community-Acquired Pneumonia
* Intra-Abdominal Infection
* Skin and Skin Structure Infection

Exclusion Criteria
N/A

Required Medical Information
1. For complicated bacterial skin and skin structure infections:
   a. Pt has had a positive culture within the past month for ANY of the following:
2. For community acquired bacterial pneumonia:
   a. Pt has had a positive culture within the past month for ANY of the following:
      i. Streptococcus pneumonia (penicillin-susceptible isolates),
      ii. Haemophilus influenza (beta-lactamase negative isolates),
      iii. Legionella pneumophila,
3. For complicated bacterial intra-abdominal infections:
   a. Pt has had a positive culture within the past month for ANY of the following:

Age Restrictions
18 years old or older

Updated 2/28/2020
Prescriber Restrictions
Infectious Disease Specialist

Coverage Duration
1 Month

Other Criteria
BvsD determination
TYKERB

Drugs
LAPATINIB 250 MG ORAL TABLET [TYKERB]

Covered Uses
* Breast Cancer

Exclusion Criteria
N/A

Required Medical Information
1. For advanced or metastatic HER-2 positive breast cancer dx:
   a. Previous failure on anthracycline, taxane, and trastuzumab AND
   b. Combination therapy with capecitabine OR
   c. Combination therapy with trastuzumab,
2. For postmenopausal HER-2 receptor hormone receptor positive breast cancer dx:
   a. Combination therapy with aromatase inhibitor

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
TYMLOS

Drugs
TYMLOS

Covered Uses
* Osteoporosis

Exclusion Criteria
1. Treatment longer than 24 months

Required Medical Information
1. T-score of less than equal to -2.5,
2. Pt has previous trial or intolerance or contraindication to bisphosphonate therapy (IV or oral),
3. Pt has previous trial on Prolia

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, Rheumatologist, Gynecologist, Orthopedist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
UPTRAVI

Drugs
UPTRAVI

Covered Uses
* Pulmonary Arterial Hypertension (PAH)

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. If pt has a positive vasoreactivity test:
      i. Pt has failed maximum tolerated doses of calcium channel blockers,
   b. Pt has previous trial on at least ONE of the following:
      i. sildenafil, ii. Revatio, iii. Adcirca,
2. Reauth:
   a. Pt has been reassessed within the past 6 months.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
VALCHLOR

Drugs
VALCHLOR

Covered Uses
* Cutaneous T-Cell Lymphoma (CTCL)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previous trial on at least ONE previous skin directed therapy of the following:

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
VASODILATORS

Drugs
ORENITRAM, VENTAVIS

Covered Uses
* Pulmonary Arterial Hypertension (PAH)

Exclusion Criteria
N/A

Required Medical Information
1. For NYHA functional class II or III:
   a. Previous trial on at least one of the following:
      i. Adcirca, ii. Letairis, iii. Opsumit, iv. sildenafil, v. Tracleer,
2. Presence of functional class IV

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Cardiologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination for Ventavis

Updated 2/28/2020
VELTASSA

Drugs
VELTASSA

Covered Uses
* Hyperkalemia

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. If patient is on a ACE or ARB must meet BOTH of the following:
      i. Pt has been tried on a loop or thiazide diuretic or has a contraindication to one of these diuretics,
      ii. The dose of the ACE or ARB has been reduced in an attempt to lower serum potassium levels,
   b. Serum potassium levels between 5.1 and 6.5 mmol/L,
   c. Pt has chronic kidney disease with an eGFR of 15 to 60 mL/min

Age Restrictions
18 years old or older

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months,
Reauth: Plan Year

Other Criteria
N/A

Updated 2/28/2020
VEMLIDY

Drugs
VEMLIDY

Covered Uses
* Hepatitis B Virus (HBV)

Exclusion Criteria
Pt has decompensated hepatic impairment

Required Medical Information
Pt has previous trial on entecavir

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist, Infectious Disease Specialist, Transplant Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
VENCLEXTA

Drugs
VENETOCLAX 10 MG ORAL TABLET [VENCLEXTA], VENETOCLAX 100 MG ORAL TABLET [VENCLEXTA], VENETOCLAX 50 MG ORAL TABLET [VENCLEXTA], {14 (VENETOCLAX 10 MG ORAL TABLET [VENCLEXTA]) / 21 (VENETOCLAX 100 MG ORAL TABLET [VENCLEXTA]) / 7 (VENETOCLAX 50 MG ORAL TABLET [VENCLEXTA]) } PACK [VENCLEXTA STARTING PACK]

Covered Uses
* Chronic Lymphocytic Leukemia (CLL)
* Small Lymphocytic Leukemia (SLL)

Exclusion Criteria
N/A

Required Medical Information
Pt has trial on at least one prior treatment

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A
VERSACLOZ

Drugs
VERSACLOZ

Covered Uses
* Schizoaffective Disorder

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had an inadequate response to at least TWO antipsychotic medications, a. At least one medication must be a long-acting depot, OR 2. Pt has medical condition that prohibits the use of tablets

Age Restrictions
N/A

Prescriber Restrictions
Psychiatrist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
VERZENIO

Drugs
ABEMACICLIB 100 MG ORAL TABLET [VERZENIO], ABEMACICLIB 150 MG ORAL TABLET [VERZENIO], ABEMACICLIB 200 MG ORAL TABLET [VERZENIO], ABEMACICLIB 50 MG ORAL TABLET [VERZENIO]

Covered Uses
* Breast Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Must meet a, b, OR c of the following:
   a. Pt is postmenopausal AND is receiving Verzenio in combination with an aromatase inhibitor
   b. Pt has received prior endocrine therapy AND Verzenio will be given in combination with fulvestrant,
   c. Pt has experienced disease progression following endocrine therapy and prior chemotherapy in the metastatic setting AND Verzenio will be used as monotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
VFEND

Drugs
VORICONAZOLE, VORICONAZOLE 200 MG INJECTION

Covered Uses
* Aspergillosis
* Candidemia
* Esophageal Candidiasis
* Serious Infections caused by Scedosporium Apiospermum and Fusarium Species

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

VITRAKVI

Drugs
VITRAKVI

Covered Uses
* Solid Tumor

Exclusion Criteria
N/A

Required Medical Information
1. solid tumor with a NTRK gene fusion
2. Metastatic or unable to have surgery
3. Received previous treatment
4. Prescriber enrolled in the Vitrakvi Commitment Program

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan year

Other Criteria
N/A

Updated 2/28/2020
VIZIMPRO

**Drugs**
DACOMITINIB 15 MG ORAL TABLET [VIZIMPRO], DACOMITINIB 30 MG ORAL TABLET [VIZIMPRO], DACOMITINIB 45 MG ORAL TABLET [VIZIMPRO]

**Covered Uses**
* Non-Small Cell Lung Cancer (NSCLC)

**Exclusion Criteria**
N/A

**Required Medical Information**
1) First line therapy 2) EGFR exon 19 deletion or EGFR exon 21 L858R substitution

**Age Restrictions**
N/A

**Prescriber Restrictions**
Oncologist

**Coverage Duration**
12 months

**Other Criteria**
N/A

Updated 2/28/2020
VOSEVI

Drugs
VOSEVI

Covered Uses
* Hepatitis C Virus (HCV)

Exclusion Criteria
N/A

Required Medical Information
1. Confirmation of genotype

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

Coverage Duration
12 Weeks

Other Criteria
N/A

Updated 2/28/2020
VOTRIENT

Drugs
PAZOPANIB 200 MG ORAL TABLET [VOTRIENT]

Covered Uses
* Renal Cell Carcinoma (RCC)
  * Soft-Tissue Sarcoma

Exclusion Criteria
N/A

Required Medical Information
1. Soft Tissue Sarcoma dx:
   a. Previous trial on at least ONE prior therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
VYNDAQEL

Drugs
TAFAMIDIS 61 MG ORAL CAPSULE [VYNDAMAX], TAFAMIDIS MEGLUMINE 20 MG ORAL CAPSULE [VYNDAQEL]

Covered Uses
* Cardiomyopathy

Exclusion Criteria
1. Use in combination with Onpattro or Tegsedi

Required Medical Information
I. For cardiomyopathy of hereditary transthyretin-mediated amyloidosis (ATTR-CM)
   A. Applicable mutation to the transthyretin (TTR) gene (e.g., Val122Ile, Thr60Ala, or Ile68Leu)
   B. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF])
II. For cardiomyopathy of wild type transthyretin-mediated amyloidosis (ATTR-CM)
   B. Negative for monoclonal protein in blood or urine (evaluated by serum free light chains and serum protein electrophoresis with urine immunofixation)
   C. Absence of monoclonal proteins has the patient undergone nuclear scintigraphy diagnosis OR presence of monoclonal proteins has the patient undergone tissue biopsy to rule out light chain cardiac amyloidosis
   D. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF])

Age Restrictions
18 years of age or older

Prescriber Restrictions
Prescriber specializes in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM)

Coverage Duration
Plan Year

Updated 2/28/2020
Other Criteria
N/A
XALKORI

Drugs
CRIZOTINIB 200 MG ORAL CAPSULE [XALKORI], CRIZOTINIB 250 MG ORAL CAPSULE [XALKORI]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
1. Combination therapy with other chemotherapy agents

Required Medical Information
1. NSCLC must be ONE of the following:
   a. Anaplastic lymphoma kinase (ALK)-positive,
   b. Reactive oxygen species 1 (ROS1) positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

XELJANZ

Drugs
24 HR TOFACITINIB 11 MG EXTENDED RELEASE ORAL TABLET [XELJANZ], TOFACITINIB 10 MG ORAL TABLET [XELJANZ], TOFACITINIB 5 MG ORAL TABLET [XELJANZ]

Covered Uses
* Psoriatic Arthritis (PsA)
* Rheumatoid Arthritis (RA)
* Ulcerative Colitis (UC)

Exclusion Criteria
1. Combination with biologic DMARD or potent immunosuppressant

Required Medical Information
1. Pt has previous trial on at least TWO of the following for PsA or RA:
2. Pt has previous trial on at least TWO of the following for UC:
   a. Entyvio, b. Humira, c. Renflexis,

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Gastroenterologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XENAZINE

Drugs
TETRABENAZINE

Covered Uses
* Huntington's Disease
* Tardive Dyskinesia

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XERMELO

Drugs
XERMELO

Covered Uses
* Carcinoid

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Pt has more than 6 bowel movements a day despite treatment with sandostatin analog therapy for at least 3 months
   b. Pt has previous trial of lomotil AND loperamide
   c. Xermelo will be used in combination with sandostatin analog
2. Reauth:
   a. Pt has experienced improvement in bowel movement frequency since starting Xermelo

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or gastroenterologist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

XGEVA

Drugs
XGEVA

Covered Uses
* Bone Metastases
* Giant Cell Tumor of the Bone
* Hypercalcemia

Exclusion Criteria
N/A

Required Medical Information
1. Must meet at least ONE of the following:
   a. Pt has giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity,
   b. Pt has a diagnosis of bone metastases related to a solid tumor,
   c. Pt has a diagnosis of metastatic breast or prostate cancer,
   d. Pt has previously been treated with Zometa and had disease progression OR adverse reaction to the treatment

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
BvsD determination

Updated 2/28/2020
**XIFAXAN**

**Drugs**
- XIFAXAN

**Covered Uses**
- * Clostridium Difficile (C.Diff) Infection
- * Hepatic Encephalopathy
- * Irritable Bowel Syndrome (IBS)

**Exclusion Criteria**
- N/A

**Required Medical Information**
1. For hepatic encephalopathy dx:
   - a. Previous failure on lactulose therapy,
2. For irritable bowel syndrome dx:
   - a. Failure on at least ONE antispasmodic therapy (e.g. dicyclomine) AND at least ONE antibiotic therapy (e.g. metronidazole, neomycin),
3. For Clostridium difficile dx:
   - a. Failure on at least TWO other antibiotic therapies (e.g. metronidazole, vancomycin, rifampin)

**Age Restrictions**
- N/A

**Prescriber Restrictions**
- Gastroenterologist, Infectious Disease Specialist, or Hepatologist

**Coverage Duration**
- Plan Year

**Other Criteria**
- N/A

Updated 2/28/2020
XIIDRA

Drugs
XIIDRA

Covered Uses
* Xerophthalmia

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Ophthalmologist or Optometrist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XOLAIR

Drugs
XOLAIR

Covered Uses
* Asthma
* Chronic Idiopathic Urticaria

Exclusion Criteria
N/A

Required Medical Information
1. For asthma dx:
   a. FEV1 baseline between 40 and 80% of predicted,
   b. Pt has previous trial (or documented contraindication) of at least ONE of the following for at least 3 months:
      i. Medium dose ICS and inhaled long-acting bronchodilator,
      ii. Medium dose ICS and leukotriene antagonist,
      iii. Medium dose ICS and theophylline,
      iv. High dose ICS and inhaled long-acting bronchodilator,
      v. Low dose ICS and inhaled long-acting bronchodilator,
   c. Pt has had need for frequent intermittent use of oral corticosteroids,
   d. Pt has at least ONE of the following:
      i. ER visit or hospitalization for asthma within past 6 months,
      ii. Need for frequent office visits due to asthma evaluation,
   e. Pt's IgE level is greater than or equal to 30, f. Pt is less than 330 lbs,
2. For CIU dx:
   a. Pt has previous failure on a H-1 antagonist,
   b. Pt has required at least one recent course of oral steroids

Age Restrictions
N/A

Updated 2/28/2020
Prescriber Restrictions
Allergist, Pulmonologist, Dermatologist, or Immunologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination
XOSPATA

Drugs
GILTERITINIB 40 MG ORAL TABLET [XOSPATA]

Covered Uses
* Acute Myelogenous Leukemia (AML)

Exclusion Criteria
N/A

Required Medical Information
1. Relapsed or refractory AML
2. Patient has a FLT3 mutation detected by an FDA-approved test

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or hematologist

Coverage Duration
Plan year

Other Criteria
N/A

Updated 2/28/2020
XPOVIO

Drugs
XPOVIO 100 MG ONCE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY

Covered Uses
* Multiple Myeloma

Exclusion Criteria
N/A

Required Medical Information
A. Diagnosis of relapsed or refractory multiple myeloma
B. Previous use of at least four prior therapies
C. Refractory to at least two proteasome inhibitors
D. Refractory to at least two immunomodulatory agents
E. Refractory to an anti-CD38 monoclonal antibody

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XTANDI

Drugs
ENZALUTAMIDE 40 MG ORAL CAPSULE [XTANDI]

Covered Uses
* Prostate Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Pt's prostate cancer is castration resistant,
2. For all dx: Pt has previous trial on docetaxel therapy
3. For metastatic CRPC dx: Pt has previous trial on Zytiga

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XURIDEN

Drugs
XURIDEN

Covered Uses
* hereditary orotic aciduria

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Medical Geneticist or Metabolic Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
XYREM

Drugs
XYREM

Covered Uses
* Narcolepsy

Exclusion Criteria
1. Succinic semialdehyde dehydrogenase deficiency,
2. Concurrent use of alcohol, opiates, sedatives, hypnotics, or other drug that causes CNS depression

Required Medical Information
1. Initial:
   a. For narcolepsy without cataplexy:
      i. exhibits symptoms of excessive daytime sleepiness
      ii. intolerant to at least one stimulant,
      iii. inadequate response to maximum recommended dose of modafinil or armodafinil,
   b. For narcolepsy with cataplexy:
      i. exhibits symptoms of cataplexy,
2. Reauth:
   a. For narcolepsy:
      i. Decrease in daytime sleepiness,
   b. For narcolepsy with cataplexy:
      i. Decrease in cataplexy episodes

Age Restrictions
7 years old or older

Prescriber Restrictions
Board certified in Sleep, Pulmonology, or Neurology

Updated 2/28/2020
Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
YONSA

Drugs
YONSA

Covered Uses
* Prostate Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Pt has failed treatment with Zytiga
2. Yonsa will be given in combination with an oral corticosteroid

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ZARXIO

Drugs
0.5 ML FILGRASTIM-AAFI 0.6 MG/ML PREFILLED SYRINGE [NIVESTYM], 0.8 ML FILGRASTIM-AAFI 0.6 MG/ML PREFILLED SYRINGE [NIVESTYM], ZARXIO

Covered Uses
* Acute Myeloid Leukemia following induction or consolidation therapy
* Myeloablative Chemotherapy followed by Bone Marrow Transplantation
* Myelosuppressive Chemotherapy for Non-Myeloid Malignancies
* Peripheral Blood Progenitor Cell Collection and Therapy
* Severe Chronic Neutropenia

Exclusion Criteria
N/A

Required Medical Information
1. Pt has trial on BOTH of the following:
   a. Neupogen, b. Granix

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

Updated 2/28/2020
ZAVESCA

Drugs
MIGLUSTAT

Covered Uses
* Gaucher Disease

Exclusion Criteria
N/A

Required Medical Information
1. Pt was diagnosed by a Clinical Biomedical Geneticist,
2. Pt is unable to use intravenous enzyme replacement

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ZEJULA

Drugs
ZEJULA

Covered Uses
* Ovarian Cancer

Exclusion Criteria
N/A

Required Medical Information
1. Pt has previously been treated with platinum-based chemotherapy,
2. Zejula will be initiated within 8 weeks of last platinum-containing regimen

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ZELBORAF

Drugs
COTELLIC, ZELBORAF

Covered Uses
* Erdheim-Chester Disease
* Malignant Melanoma

Exclusion Criteria
N/A

Required Medical Information
1. For Metastatic Melanoma dx:
   a. Pt is BRAF V600E positive for Zelboraf monotherapy OR
   b. BRAF V600E or V600K positive for Zelboraf plus Cotellie
2. For Erdheim-Chester Disease:
   a. Zelboraf monotherapy
   b. Pt is BRAF V600 positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

ZOLINZA

Drugs
VORINOSTAT 100 MG ORAL CAPSULE [ZOLINZA]

Covered Uses
* Cutaneous T-Cell Lymphoma (CTCL)

Exclusion Criteria
N/A

Required Medical Information
1. Pt has progressive, persistent, or recurrent disease,
2. Pt has tried at least TWO prior systemic therapies

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ZYDELIG

Drugs
ZYDELIG

Covered Uses
* Chronic Lymphocytic Leukemia (CLL)
* Non-Hodgkin's Lymphoma (NHL)

Exclusion Criteria
N/A

Required Medical Information
1. CLL dx:
   a. Used in combination with Rituxan,
2. Non-Hodgkin dx:
   a. Pt has failure of two prior systemic therapies,
3. Small Lymphocytic Lymphoma dx:
   a. Pt has failure of two prior systemic therapies

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
ZYKADIA

Drugs
CERITINIB 150 MG ORAL TABLET [ZYKADIA]

Covered Uses
* Non-Small Cell Lung Cancer (NSCLC)

Exclusion Criteria
1. Combination therapy

Required Medical Information
1. Pt has previous trial on Xalkori

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

ZYTGIA

Drugs
ABIRATERONE ACETATE, ZYTIGA

Covered Uses
* Prostate Cancer

Exclusion Criteria
N/A

Required Medical Information
1. For metastatic CRPC dx:
   a. Zytiga is given in combination with prednisone 5mg twice daily
2. For metastatic high-risk CSPC dx:
   a. Zytiga is given in combination with prednisone 5 mg once daily

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 2/28/2020
SelectHealth Advantage
2020 Prior Authorization Criteria

Index

Acromegaly.................................................................1
Acmetra.................................................................2
Actimmune..............................................................3
Adempas.................................................................4
Aimovig.................................................................5
Ajovy.......................................................................7
Albenza.................................................................9
Alecsena...............................................................10
Amphob.................................................................11
Ampyra.................................................................13
Androgens............................................................14
Antibiotics............................................................15
Apo B..................................................................16
Apokyn..............................................................18
Arcalyt...............................................................19
Arikayed..............................................................20
Balversa..............................................................21
Banzel.................................................................22
Benlysta.............................................................23
Bosulif...............................................................24
Braftovi..............................................................25
Cablovi...............................................................26
Cabometyx..........................................................27
Calquence..........................................................28
Cancidas............................................................29
Caprelsa............................................................30
Carbaglu............................................................31
Carperia.............................................................32
Cesamet.............................................................33
Cholbam............................................................34
Cimzia...............................................................36
Cometiq............................................................37
Copiktra............................................................38
Cosentyx...........................................................39

Crinone.............................................................40
Cystagon............................................................41
Cystaran............................................................42
Cystic Fibrosis..................................................43
Daurismo...........................................................44
Depen...............................................................45
Dificid...............................................................46
Doptlet..............................................................47
Dronabinol.........................................................48
Dupixent............................................................49
Emgality.............................................................50
Enbrel...............................................................52
Endothelin Antagonist.......................................53
Epclusa.............................................................54
Epidiolex............................................................55
Erivedge............................................................56
Erleada.............................................................57
Evenity.............................................................58
Fareston.............................................................60
Farydak............................................................61
Fasenra............................................................62
Fentanyl............................................................63
Firazyr.............................................................64
Firdapse............................................................65
Fluorouracil.......................................................67
Forteo..............................................................68
Galafold............................................................69
Gattez..............................................................70
Gilotrif.............................................................71
Gleostine...........................................................72
Growth Hormone..............................................73
Haegarda...........................................................75
Harvoni............................................................76
Hepatitis C ........................................................77
Hetlioz..............................................................79
Humira............................................................80
Humulin U500...................................................82
Ibrance.............................................................83
Iclusig.............................................................84
Idhifa..............................................................85
Illumya............................................................86
Imbruvica........................................................87
Immunotherapy..................................................88
Inbrija.............................................................89
Inclex.............................................................90
Ingrezzia........................................................91
Inlyta............................................................92
Inrebic..........................................................93
Iressa............................................................94
Ivig...............................................................95
Jadenu...........................................................97
Jakafi...........................................................99
Jynarque........................................................100
Kaldeco........................................................101
Kevzara........................................................102
Kinetro........................................................103
Kisqali..........................................................104
Korlym........................................................105
Lenvima........................................................106
Lidoderm.........................................................108
Lonsurf........................................................109
Lorbran........................................................110
Lucemyra.......................................................111
Lupaneta.........................................................112
Lynparza.........................................................113
Mavenclad......................................................114
Mayvret.........................................................115
Mayzent.........................................................116

Updated 2/28/2020
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mekinist</td>
<td>117</td>
</tr>
<tr>
<td>Migranal</td>
<td>118</td>
</tr>
<tr>
<td>Ms</td>
<td>119</td>
</tr>
<tr>
<td>Mulpleta</td>
<td>120</td>
</tr>
<tr>
<td>Myalept</td>
<td>121</td>
</tr>
<tr>
<td>Nafcillin</td>
<td>122</td>
</tr>
<tr>
<td>Natpara</td>
<td>123</td>
</tr>
<tr>
<td>Nerlynx</td>
<td>124</td>
</tr>
<tr>
<td>Nexavar</td>
<td>125</td>
</tr>
<tr>
<td>Ninlaro</td>
<td>126</td>
</tr>
<tr>
<td>Nitrofuran</td>
<td>127</td>
</tr>
<tr>
<td>Northera</td>
<td>128</td>
</tr>
<tr>
<td>Nourianz</td>
<td>129</td>
</tr>
<tr>
<td>Noxafil</td>
<td>130</td>
</tr>
<tr>
<td>Nubeqa</td>
<td>131</td>
</tr>
<tr>
<td>Nuedexta</td>
<td>132</td>
</tr>
<tr>
<td>Nuprazid</td>
<td>133</td>
</tr>
<tr>
<td>Ocaliva</td>
<td>134</td>
</tr>
<tr>
<td>Octreotide</td>
<td>136</td>
</tr>
<tr>
<td>Olumiant</td>
<td>138</td>
</tr>
<tr>
<td>Onfi</td>
<td>139</td>
</tr>
<tr>
<td>Orencia</td>
<td>140</td>
</tr>
<tr>
<td>Orfadin</td>
<td>141</td>
</tr>
<tr>
<td>Orilissa</td>
<td>142</td>
</tr>
<tr>
<td>Orkambi</td>
<td>143</td>
</tr>
<tr>
<td>Otezla</td>
<td>144</td>
</tr>
<tr>
<td>Pah</td>
<td>145</td>
</tr>
<tr>
<td>Palynziq</td>
<td>146</td>
</tr>
<tr>
<td>Panretin</td>
<td>147</td>
</tr>
<tr>
<td>Phenoxybenzamine</td>
<td>148</td>
</tr>
<tr>
<td>Piqray</td>
<td>149</td>
</tr>
<tr>
<td>Pomalyst</td>
<td>150</td>
</tr>
<tr>
<td>Prefest</td>
<td>151</td>
</tr>
<tr>
<td>Prevymis</td>
<td>152</td>
</tr>
<tr>
<td>Primaxin</td>
<td>153</td>
</tr>
<tr>
<td>Promacta</td>
<td>155</td>
</tr>
</tbody>
</table>

**SelectHealth Advantage**  
**2020 Prior Authorization Criteria**

| Proteinase Inhibitor     | 157   |
| Pulmonary Fibrosis       | 158   |
| Purixan                 | 159   |
| Rcc                      | 160   |
| Relistor                 | 162   |
| Repatha                  | 163   |
| Restasis                 | 165   |
| Revlimid                 | 166   |
| Rinvoq                   | 167   |
| Rozlytrek                | 168   |
| Rubraca                  | 169   |
| Rydapt                   | 170   |
| Sabril                   | 171   |
| Sensipar                 | 172   |
| Signifor                 | 173   |
| Sirturo                  | 174   |
| Sitavig                  | 175   |
| Skyrizi                  | 176   |
| Sprycel                  | 177   |
| Stelara                  | 178   |
| Stivarga                 | 180   |
| Sucraid                  | 181   |
| Sutent                   | 182   |
| Sylatron                 | 183   |
| Symdeko                  | 184   |
| Synarel                  | 185   |
| Synribo                  | 186   |
| Syprine                  | 187   |
| Tafinlar                 | 188   |
| Tagrisso                 | 189   |
| Talzenna                 | 190   |
| Tarceva                  | 191   |
| Targretin                | 192   |
| Tasigna                  | 193   |
| Tavalisce                | 194   |
| Teflaro                  | 196   |
| Tegsedi                  | 198   |
| Temazepam                | 199   |
| Thioridazine             | 200   |
| Tibsovo                  | 201   |
| Trikafta                 | 202   |
| Trokendi                 | 203   |
| Turalio                  | 204   |
| Tygacil                  | 205   |
| Tykerb                   | 207   |
| Tymlos                   | 208   |
| Uptravi                  | 209   |
| Valchlor                 | 210   |
| Vasodilators             | 211   |
| Veltassa                 | 212   |
| Venlidy                  | 213   |
| Venclexa                 | 214   |
| Versacloz                | 215   |
| Verzenio                 | 216   |
| Vfend                    | 217   |
| Vitakrvi                 | 218   |
| Vizimpro                 | 219   |
| Vosevi                   | 220   |
| Votrient                 | 221   |
| Vyndaqel                 | 222   |
| Xalkori                  | 224   |
| Xeljanz                  | 225   |
| Xenazine                 | 226   |
| Xermelo                  | 227   |
| Xgeva                    | 228   |
| Xifaxan                  | 229   |
| Xiidra                   | 230   |
| Xolair                   | 231   |
| Xospata                  | 233   |
| Xpovio                   | 234   |
| Xtandi                   | 235   |
| Xuriden                  | 236   |
Xyrem ............................................................. 237
Yonsa ............................................................. 239
Zarxio .............................................................. 240
Zavesca ........................................................... 241
Zejula .............................................................. 242
Zelboraf ........................................................... 243
Zolinza ............................................................ 244
Zydelig ............................................................. 245
Zykadia ............................................................ 246
Zytiga ............................................................... 247

Updated 2/28/2020