

## **ABALOPARATIDE (TYMLOS)**

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### **MEDICATION(S)**

TYMLOS

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 years

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

# APREMILAST

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## MEDICATION(S)

OTEZLA

## PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

## OFF LABEL USES

N/A

## EXCLUSION CRITERIA

N/A

## REQUIRED MEDICAL INFORMATION

N/A

## AGE RESTRICTION

N/A

## PRESCRIBER RESTRICTION

N/A

## COVERAGE DURATION

1 year

## OTHER CRITERIA

N/A

## PART B PREREQUISITE

N/A

## **BEXAROTENE (TARGRETIN)**

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### **MEDICATION(S)**

BEXAROTENE 1 % GEL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **C1 ESTERASE INHIBITOR**

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### **MEDICATION(S)**

CINRYZE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CANNABIDIOL (EPIDIOLEX)**

---

### **MEDICATION(S)**

EPIDIOLEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DALFAMPRIDINE (AMPYRA)**

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### **MEDICATION(S)**

DALFAMPRIDINE ER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DARBEPOETIN (ARANESP)**

---

### **MEDICATION(S)**

ARANESP (ALBUMIN FREE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DENOSUMAB (XGEVA)**

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### **MEDICATION(S)**

XGEVA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **DEXTROMETHORPHAN/QUINIDINE (NUEDEXTA)**

---

### **MEDICATION(S)**

NUEDEXTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DICLOFENAC (SOLARAZE)**

---

### **MEDICATION(S)**

DICLOFENAC SODIUM 3 % GEL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DICLOFENAC EPOLAMINE**

---

### **MEDICATION(S)**

DICLOFENAC EPOLAMINE

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

# **DRONABINOL**

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## **MEDICATION(S)**

DRONABINOL

## **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

## **OFF LABEL USES**

N/A

## **EXCLUSION CRITERIA**

N/A

## **REQUIRED MEDICAL INFORMATION**

N/A

## **AGE RESTRICTION**

N/A

## **PRESCRIBER RESTRICTION**

N/A

## **COVERAGE DURATION**

1 year

## **OTHER CRITERIA**

N/A

## **PART B PREREQUISITE**

N/A

## **DULOXETINE (DRIZALMA SPRINKLE)**

---

### **MEDICATION(S)**

DRIZALMA SPRINKLE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DUPILUMAB**

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### **MEDICATION(S)**

DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ELBASVIR AND GRAZOPREVR (ZEPATIER)**

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### **MEDICATION(S)**

ZEPATIER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12-16 weeks

### **OTHER CRITERIA**

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

### **PART B PREREQUISITE**

N/A

## **EPOETIN (EPOGEN)**

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### **MEDICATION(S)**

RETACRIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **FILGRASTIM (NEUPOGEN)**

---

### **MEDICATION(S)**

NIVESTYM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

not for afebrile neutropenia

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

6 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FREMANEZUMAB (AJOVY)**

---

### **MEDICATION(S)**

AJOVY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **GLECAPREVIR/PIBRENTASVIR (MAVYRET)**

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### **MEDICATION(S)**

MAVYRET 100-40 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD/IDSA guidance

### **PART B PREREQUISITE**

N/A

## **LEDIPASVIR/SOFOSBUVIR (HARVONI)**

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### **MEDICATION(S)**

LEDIPASVIR-SOFOSBUVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks in patients without cirrhosis, 24 weeks in patients with cirrhosis

### **OTHER CRITERIA**

Documentation of medical necessity and inability to use BOTH of the following preferred agents:  
sofosbuvir-velpatasvir or glecaprevir-pibrentasvir

### **PART B PREREQUISITE**

N/A

# LIDOCAINE

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## **MEDICATION(S)**

LIDOCAINE 5 % PATCH, TRIDACAINE III

## **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

## **OFF LABEL USES**

N/A

## **EXCLUSION CRITERIA**

N/A

## **REQUIRED MEDICAL INFORMATION**

N/A

## **AGE RESTRICTION**

N/A

## **PRESCRIBER RESTRICTION**

N/A

## **COVERAGE DURATION**

12 months

## **OTHER CRITERIA**

N/A

## **PART B PREREQUISITE**

N/A

## **LOMITAPIDE**

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### **MEDICATION(S)**

JUXTAPID

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

# MACITENTAN

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## MEDICATION(S)

OPSUMIT

## PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

## OFF LABEL USES

N/A

## EXCLUSION CRITERIA

N/A

## REQUIRED MEDICAL INFORMATION

N/A

## AGE RESTRICTION

N/A

## PRESCRIBER RESTRICTION

N/A

## COVERAGE DURATION

1 year

## OTHER CRITERIA

N/A

## PART B PREREQUISITE

N/A

## **MEPOLIZUMAB (NUCALA)**

---

### **MEDICATION(S)**

NUCALA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **METHYLNALTREXONE (RELISTOR)**

---

### **MEDICATION(S)**

RELISTOR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MIFEPRISTONE**

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### **MEDICATION(S)**

MIFEPRISTONE 300 MG TAB

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

# MODAFINIL

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## MEDICATION(S)

MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

## PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

## OFF LABEL USES

N/A

## EXCLUSION CRITERIA

N/A

## REQUIRED MEDICAL INFORMATION

N/A

## AGE RESTRICTION

N/A

## PRESCRIBER RESTRICTION

N/A

## COVERAGE DURATION

1 year

## OTHER CRITERIA

N/A

## PART B PREREQUISITE

N/A

# OMALIZUMAB

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## MEDICATION(S)

XOLAIR

## PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

## OFF LABEL USES

N/A

## EXCLUSION CRITERIA

N/A

## REQUIRED MEDICAL INFORMATION

N/A

## AGE RESTRICTION

N/A

## PRESCRIBER RESTRICTION

N/A

## COVERAGE DURATION

1 year

## OTHER CRITERIA

N/A

## PART B PREREQUISITE

N/A

## **PART D VS PART B**

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### **MEDICATION(S)**

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, APREPITANT, ARALAST NP, ASTAGRAF XL, AZATHIOPRINE 100 MG TAB, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 75 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CINACALCET HCL, CLINIMIX E/DEXTROSE (2.75/5), CLINIMIX E/DEXTROSE (4.25/10), CLINIMIX E/DEXTROSE (4.25/5), CLINIMIX E/DEXTROSE (5/15), CLINIMIX E/DEXTROSE (5/20), CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), CLINISOL SF, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, ELIGARD, ENGERIX-B, ENVARUSUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, GAMMAGARD 2.5 GM/25ML SOLUTION, GAMMAGARD S/D LESS IGA, GAMMAPLEX 10 GM/100ML SOLUTION, GAMMAPLEX 10 GM/200ML SOLUTION, GAMMAPLEX 20 GM/200ML SOLUTION, GAMMAPLEX 5 GM/50ML SOLUTION, GAMUNEX-C 1 GM/10ML SOLUTION, GLASSIA, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION, HEPLISAV-B, INTRALIPID, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, LUPRON DEPOT, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE, PREMASOL, PRIVIGEN 20 GM/200ML SOLUTION, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROLASTIN-C, PROSOL, PULMOZYME, RECOMBIVAX HB, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TAB, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN, TRAVASOL, TROPHAMINE, VORICONAZOLE 200 MG RECON SOLN, ZEMAIRA

**DETAILS**

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

## **PIMAVANSERIN TARTRATE (NUPLAZID)**

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### **MEDICATION(S)**

NUPLAZID

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RIOCIGUAT**

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### **MEDICATION(S)**

ADEMPAS

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **SARGRAMOSTIM (LEUKINE)**

---

### **MEDICATION(S)**

LEUKINE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SEMAGLUTIDE (OZEMPIC)**

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### **MEDICATION(S)**

OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE), OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SILDENAFIL CITRATE (REVATIO)**

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### **MEDICATION(S)**

SILDENAFIL CITRATE 20 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SODIUM OXYBATE**

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### **MEDICATION(S)**

SODIUM OXYBATE

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SOFOSBUVIR (SOLVALDI)**

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### **MEDICATION(S)**

SOVALDI 400 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Criteria will be applied consistent with current AASLD-IDSA guidance

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD-IDSA guidance

### **PART B PREREQUISITE**

N/A

## **SOFOSBUVIR AND VELPATASVIR (EPCLUSA)**

---

### **MEDICATION(S)**

SOFOSBUVIR-VELPATASVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD/IDSA guidance

### **PART B PREREQUISITE**

N/A

## **SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)**

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### **MEDICATION(S)**

VOSEVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

Criteria will be applied consistent with current AASLD/IDSA guidance

### **PART B PREREQUISITE**

N/A

# SOMATROPIN

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## **MEDICATION(S)**

GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, OMNITROPE, SEROSTIM

## **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

## **OFF LABEL USES**

N/A

## **EXCLUSION CRITERIA**

N/A

## **REQUIRED MEDICAL INFORMATION**

N/A

## **AGE RESTRICTION**

N/A

## **PRESCRIBER RESTRICTION**

N/A

## **COVERAGE DURATION**

12 months

## **OTHER CRITERIA**

N/A

## **PART B PREREQUISITE**

N/A



## **TADALAFIL (ADCIRCA)**

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### **MEDICATION(S)**

TADALAFIL (PAH)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TADALAFIL 5MG**

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### **MEDICATION(S)**

TADALAFIL 5 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TASIMELTEON**

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### **MEDICATION(S)**

HETLIOZ LQ, TASIMELTEON

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TEDUGLUTIDE (GATTEX)**

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### **MEDICATION(S)**

GATTEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 months

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TERIPARATIDE (FORTEO)**

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### **MEDICATION(S)**

TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

2 years

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TIRZEPATIDE (MOUNJARO)**

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### **MEDICATION(S)**

MOUNJARO

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TOFACITINIB**

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### **MEDICATION(S)**

XELJANZ, XELJANZ XR

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

1 year

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VARENICLINE (CHANTIX)**

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### **MEDICATION(S)**

VARENICLINE TARTRATE, VARENICLINE TARTRATE (STARTER), VARENICLINE TARTRATE(CONTINUE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

12 weeks

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A