2020 Prior Authorization (PA) Criteria

Certain drugs require prior authorization from ConnectiCare Medicare Advantage Plans. This means that your doctor must contact us to get approval before prescribing the drug to you. If your doctor does not get prior approval, the drug may not be covered.

This list also includes drugs that may be covered under Medicare Part B or Part D depending on how the drugs are used or administered. If your drug is on this list, your doctor should call us and provide information describing the use and administration of the drug so we can advise on whether the drug will be covered.

To see if your drug is on the list, refer to the index located at the end of this document for the medication you are looking for or click this **Search** button and enter the name of your drug in the pop-up task pane.

ConnectiCare

ACTHAR

Products Affected

- Acthar

PA Criteria	Criteria Details
Exclusion Criteria	Use in patients with multiple sclerosis (MS) as pulse therapy on a monthly basis. Use as maintenance therapy in patients with psoriatic arthritis, rheumatoid arthritis, or ankylosing spondylitis. Treatment of proteinuria in diabetic nephropathy.
Required Medical Information	MS exacerbation, rheumatic disorder exacerbation, history of corticosteroid use
Age Restrictions	N/A
Prescriber Restrictions	Infantile spasms, prescribed by or in consultation with a neurologist or an epileptologist. MS exacerbation, prescribed by or in consultation with a neurologist or physician that specializes in the treatment of MS. Rheumatic disorder exacerbation, prescribed by or in consultation with a rheumatologist.
Coverage Duration	One month
Other Criteria	For MS exacerbation and rheumatic disorder exacerbation, approve if the patient cannot use high-dose IV corticosteroids because IV access is not possible or if the patient has tried high-dose corticosteroids administered IV for an acute exacerbation and has experienced a severe or limiting adverse effect. (Applies only to beneficiaries enrolled in an MA-PD plan.)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	12 months
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is not required in pts who are currently receiving Adempas or another agent indicated for WHO group 1.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz oral tablet for suspension 2 mg, 3 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or a Neurologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmed ALK-positive NSCLC as detected by an FDA-approved test and prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC): The patient has metastatic ALK-positive NSCLC as detected by an FDA-approved test AND The patient has progressed on or are intolerant to Xalkori (crizotinib)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ALOSETRON

Products Affected

- alosetron

PA Criteria	Criteria Details
Exclusion Criteria	Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) alosetron is being prescribed for a woman AND chronic IBS symptoms have lasted at least 6 months AND gastrointestinal tract abnormalities have been ruled out AND the patient has had inadequate response to conventional therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ALUNBRIG

Products Affected

- Alunbrig oral tablet 180 mg, 30 mg, 90 mg
- Alunbrig oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other chemotherapy, patients with ALK-negative NSCLC, pediatric patients less than 18 years of age
Required Medical Information	Diagnosis, prior therapies, ALK-positive NSCLC confirmed by an FDA-approved test
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	3 years
Other Criteria	For NSCLC, patient has metastatic or recurrent disease that is ALK-positive as detected by an FDA-approved test AND patient has progressed on Xalkori (crizotinib)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

AMBRISENTAN

Products Affected

- ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, idiopathic pulmonary fibrosis, including idiopathic pulmonary fibrosis patients with pulmonary hypertension (WHO group 3).
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	12 months
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on ambrisentan or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on ambrisentan or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ANTICONVULSANTS

Products Affected

- topiramate oral capsule, sprinkle
- topiramate oral capsule,sprinkle,ER 24hr
- topiramate oral tablet
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

APTIOM

Products Affected

- Aptiom

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	Rilonacept should not be given in combination with biologic therapy (e.g. tumor necrosis factor (TNF) blocking agents (eg, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), anakinra, or canakinumab).
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, geneticist, dermatologist or immunologist.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	Patients with a known hypersensitivity to any aminoglycoside. Patients with non-refractory MAC lung disease.
Required Medical Information	Diagnosis. Previous therapies tried. Current therapy regimen.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist.
Coverage Duration	Initial approval: 6 months. Renewal: 12 months.
Other Criteria	Initial: The patient must have a diagnosis of Mycobacterium avium complex (MAC) lung disease as confirmed by a MAC-positive sputum culture AND the patient must have a positive sputum culture obtained after at least 6 months of a multi-drug regimen for MAC lung disease with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol AND Arikayce must be used as part of a multi-drug regimen and will not be approved for use as a single agent. Renewal: Patient has demonstrated response to therapy with the addition of Arikayce, defined as a negative sputum culture obtained within the last 30 days of renewal. Patients that have had negative cultures for 1 year will not be approved for continued treatment. Treatment beyond the first recertification approval (after 18 months) will require documentation of a positive sputum culture to demonstrate the need for continued treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ARMODAFINIL

Products Affected

- armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	Patients with known hypersensitivity to modafinil
Required Medical Information	Diagnosis
Age Restrictions	17 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For excessive sleepiness due to SWSD, the patient is working at least 5 overnight shifts per month.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried, presence of susceptible FGFR genetic alterations in tumor specimens as detected by an FDA-approved companion diagnostic.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For locally advanced or metastatic urothelial carcinoma, patient must have susceptible FGFR3 or FGFR2 genetic alterations AND must have progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BENLYSTA

Products Affected

- Benlysta subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Patients with severe lupus nephritis or severe active central nervous system lupus, concurrent use with other biologics or intravenous cyclophosphamide
Required Medical Information	Diagnosis, patient has active, autoantibody-positive, systemic lupus erythematosus and is receiving standard therapy
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, or a physician that specializes in diseases of joints and muscles
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BEXAROTENE

Products Affected

- bexarotene
- Targretin topical

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis, prior therapies tried. For female patients of child bearing potential, a negative pregnancy test will be obtained within one week prior to bexarotene gel therapy, and the pregnancy test will be repeated at monthly intervals while the patient remains on therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For oral bexarotene, for a diagnosis of primary cutaneous T cell lymphoma, patient is refractory to one prior systemic therapy. For bexarotene gel, for the topical treatment of cutaneous lesions, patients have refractory or persistent CTCL (Stage IA and IB) after other therapies or have not tolerated other therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BOSULIF

Products Affected

- Bosulif oral tablet 100 mg, 400 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Bosulif is being used. For chronic myelogenous leukemia (CML), the Philadelphia chromosome (Ph) status of the leukemia must be reported. For CML, prior therapies tried must be reported to confirm resistance or intolerance.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	12 months
Other Criteria	For Chronic phase, accelerated phase (AP), or blast phase (BP) Ph+ CML, must have resistance or intolerance to any one prior therapy for approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BRAFTOVI

Products Affected

- Braftovi oral capsule 75 mg

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Diagnosis, BRAF mutation status as detected by an FDA-approved test, current treatment regimen
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For melanoma, patient has unresectable or metastatic disease AND the presence of the BRAF V600E or V600K mutation as detected by an FDA-approved test AND Braftovi will be used in combination with Mektovi.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

BRIVIACT

Products Affected

- Briviact oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medication history
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For hepatocellular carcinoma (HCC), patient has been previously treated with sorafenib.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	Previous treatment with a BTK inhibitor (e.g. Imbruvica)
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For mantle cell lymphoma (MCL), patient has received at least one prior therapy
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	baseline liver function tests
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
Coverage Duration	Initial approval for 3 months, continuation approval for 12 months
Other Criteria	For continuation of therapy to be approved patient must meet 2 of the 3 following lab criteria or meet 1 of the 3 follow lab criteria and have body weight increased by 10% or stable at greater than the 50th percentile. Lab criteria: (1) patient alanine aminotransferase (ALT) or aspartate aminotransferase (AST) less than 50 U/L or the baseline levels reduced by 80%, (2) patient total bilirubin level must be reduced to less than or equal to 1 mg/dL, (3) patient must not have evidence of cholestasis on liver biopsy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CLOBAZAM

Products Affected

- clobazam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient will receive clobazam for the treatment of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Previous therapies tried and failed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For relapsed or refractory chronic lymphocytic leukemia (CLL), small lymphocytic leukemia (SLL), or follicular lymphoma (FL), patient must have been previously treated with two prior therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	HF in pts not currently receiving Corlanor - must all of the following 1. have LVEF of less than or equal 35 percent, 2. have sinus rhythm and a resting HR of greater than or equal to 70 BPM, AND 3. tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - had a LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy. For the treatment of stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, patient is in sinus rhythm with an elevated heart rate.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

COSENTYX

Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	18 years and older
Prescriber Restrictions	For Psoriatic Arthritis (PsA), must be prescribed by or in consultation with a dermatologist or rheumatologist. For Ankylosing Spondylitis (AS), must be prescribed by, or in consultation with, a rheumatologist. For Plaque Psoriasis (PP), must be prescribed by or in consultation with a dermatologist.
Coverage Duration	3 years
Other Criteria	For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Presence of BRAF V600E or V600K mutation confirmed by an FDA approved test
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Unresectable or metastatic melanoma - being prescribed in combination with vemurafenib
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary amenorrhea, 12 months. Support of an established pregnancy, 9 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DALFAMPRIDINE ER

Products Affected

- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DARAPRIM

Products Affected

- Daraprim

PA Criteria	Criteria Details
Exclusion Criteria	hypersensitivity to pyrimethamine, documented megaloblastic anemia due to folate deficiency
Required Medical Information	Medication history, patient's immune status
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Malaria Prophylaxis, approve if the patient has tried at least two other antimalarials (eg, atovaquone-proguanil, chloroquine phosphate, hydroxychloroquine sulfate, doxycycline, mefloquine, and primaquine). Malaria Treatment, approve if the patient has tried at least two other antimalarials (eg, Coartem [artemether-lumefantrine tablets], quinine sulfate or quinidine gluconate in combination with doxycycline, tetracycline, or clindamycin, quinine sulfate in combination with primaquine and either doxycycline or tetracycline, or the following medications as monotherapy or in combination with primaquine: atovaquone-proguanil, mefloquine, chloroquine phosphate, and hydroxychloroquine). Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed and the patient has tried one other recommended therapy, unless contraindicated (eg, trimethoprim-sulfamethoxazole [TMP-SMX], atovaquone).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis

ConnectiCare

DAURISMO

Products Affected

- Daurismo oral tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient is newly-diagnosed with acute myeloid leukemia (AML), Medical history, Current medication regimen
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	Patient has newly-diagnosed acute myeloid leukemia (AML) AND the patient is using Daurismo in combination with low-dose cytarabine AND the patient is 75 years of age or older OR according to the prescribing physician, the patient has comorbidities that preclude the use of intensive induction chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DEMSER

Products Affected

- Demser

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DICLOFENAC GEL

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DIGOXIN

Products Affected

- Digitek oral tablet 250 mcg (0.25 mg)
- Digox oral tablet 250 mcg (0.25 mg)
- digoxin oral solution 50 mcg/mL (0.05 mg/mL)
- digoxin oral tablet 250 mcg (0.25 mg)
- Lanoxin oral tablet 250 mcg (0.25 mg)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk medication) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Exclusion Criteria	Treatment naive patients
Required Medical Information	Diagnosis, previous therapies tried and lengths of trials, percentage of body surface area affected (atopic dermatitis only), documentation confirming eosinophilic asthma phenotype or oral corticosteroid-dependent asthma (asthma only)
Age Restrictions	Atopic dermatitis: 12 years of age and older. Asthma: 12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist, immunologist, dermatologist, pulmonologist, or an ENT specialist.
Coverage Duration	Initiation 16 weeks, Continuation 12 months
Other Criteria	For atopic dermatitis initial therapy, patient has atopic dermatitis involvement estimated to be over 10% of the body surface area (BSA), AND patient has used at least one medium, medium-high, high, and/or super-high-potency prescription topical corticosteroid for at least 30 days AND the patient has tried tacrolimus ointment for at least 30 days AND inadequate efficacy was demonstrated with topical therapy, according to the prescribing physician. For atopic dermatitis continuation, approve if the patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., marked improvements in erythema, induration, papulation, edema, excoriations, and lichenification, reduced pruritus, decreased requirement for other topical or systemic therapies, reduced body surface area (BSA) affected with atopic dermatitis, or other responses observed). For asthma initial therapy, approve if the patient has moderate to severe asthma with an eosinophilic phenotype OR is dependent on oral corticosteroids AND Dupixent is being used as add-on maintenance treatment in patients receiving BOTH high-dose inhaled corticosteroids AND an additional controller medication (e.g. long-acting beta agonist, etc.) AND the patient has had two or more exacerbations in the previous year OR requires daily oral corticosteroids (for at least 3 days in addition to the regular maintenance therapies). For asthma continuation, approve if the

PA Criteria	Criteria Details
	patient has decreased use of oral corticosteroids OR has an increase in forced expiratory volume (FEV1) from pretreatment baseline OR decreased use of inhaled corticosteroids.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Exclusion Criteria	Patients less than 12 years of age. Concurrent use of SSRIs, SNRIs, clomipramine, imipramine, meperidine, tramadol, methadone, pentazocine, propoxyphene, dextromethorphan, and carbamazepine. Patients with pheochromocytoma.
Required Medical Information	Diagnosis, previous therapies tried, current therapy regimen
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a psychiatrist.
Coverage Duration	12 months
Other Criteria	The patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) AND the patient is unable to swallow oral formulations due to oral or motor difficulties, dysphagia, etc.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ENBREL

Products Affected

- Enbrel Mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous syringe 25 mg/0.5 mL (0.5), 50 mg/mL (1 mL)
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	Juvenile idiopathic arthritis (JIA)- 2 years or older. Plaque psoriasis (PP)- 4 years or older. Ankylosing spondylitis (AS), Psoriatic arthritis (PsA), Rheumatoid arthritis (RA)- 18 years and older.
Prescriber Restrictions	For RA, AS, and JIA, must be prescribed by, or in consultation with, a rheumatologist. PsA, must be prescribed by, or in consultation with, a rheumatologist or dermatologist. PP, must be prescribed by, or in consultation with, a dermatologist.
Coverage Duration	3 years
Other Criteria	For RA, patient has tried one conventional synthetic DMARD for at least 3 months. Patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD. For JIA, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD) or will be starting on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or if patient has aggressive disease. For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

ConnectiCare

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	5 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a physician who specializes in SCD (e.g., a hematologist).
Coverage Duration	12 months
Other Criteria	For Sickle Cell Disease, patient will be using Endari to reduce acute complications.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis. For patients with cirrhosis, cirrhosis must be documented by FibroScan, FibroTest ActiTest, liver biopsy, or radiological imaging.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	12 weeks, based on indication and current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Previous therapies tried
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, specializing in seizure therapy.
Coverage Duration	12 months
Other Criteria	For approval of Epidiolex, patient has a diagnosis of Lennox-Gastaut syndrome OR Dravet syndrome AND patient has refractory epilepsy after treatment with two prior therapies (e.g. lamotrigine, clobazam, clonazepam).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	12 months
Other Criteria	Metastatic or Locally advanced basal cell carcinoma (LABCC), approve if the patients BCC has recurred following surgery or the patient is not a candidate for surgery or radiation therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Nintedanib
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in combination with a pulmonologist
Coverage Duration	3 years
Other Criteria	IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

FARYDAK

Products Affected

- Farydak oral capsule 10 mg, 15 mg, 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	History of previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	12 months
Other Criteria	Must be used in combination with Velcade and dexamethasone AND previously tried Velcade and one immunomodulatory drug (i.e., Thalomid, Revlimid, or Pomalyst).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

FERRIPROX

Products Affected

- Ferriprox oral tablet 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

FIRAZYR

Products Affected

- Firazyr
- icatibant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

FYCOMPA

Products Affected

- Fycompa oral suspension
- Fycompa oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a Neurologist
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) variant.
Age Restrictions	16 years and older
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease.
Coverage Duration	12 months
Other Criteria	Patient has a documented diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) variant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For metastatic non-small cell lung cancer (NSCLC) documentation of non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test. For metastatic squamous NSCLC, documentation of prior platinum-based chemotherapy.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Exclusion Criteria	Patients with a history of serious allergic reactions to filgrastim or pegfilgrastim products. Administration within 24 hours preceding or following chemotherapy or radiotherapy.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	For cancer patients receiving chemotherapy, the patient must be receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen) OR the patient must be receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen AND the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (e.g., at least 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, HIV infection) OR the patient must have had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a CSF (e.g., filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment OR the patient has received chemotherapy, has febrile neutropenia, and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescribing physician (e.g., sepsis syndrome, older than 65 years, severe neutropenia - ANC less than 100 cells/mm3, neutropenia expected to be more than 10 days in duration,

PA Criteria	Criteria Details
	invasive fungal infection, other clinically documented infections, or prior episode of febrile neutropenia).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

GROWTH HORMONE

Products Affected

- Norditropin FlexPro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For pediatric GHD in neonate with hypoglycemia: patient has a randomly assessed GH level less than 20 ng/mL, other causes of hypoglycemia have been ruled out, and other treatments have been ineffective. For all pediatric patients: patients have short stature or slow growth velocity and have been evaluated for other causes of growth failure. For pediatric GHD, patient has delayed bone age. For pediatric GHD without pituitary disease, patient failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder, patient has clinical evidence of GHD and low IGF-1/IGFBP3. For TS and SHOX patients: diagnosis confirmed by genetic testing. For CRI patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant. For SGA: patient has a low birth weight or length for gestational age. For ISS: pediatric GHD has been ruled out with one stimulation test. For adult GHD, patient was assessed for other causes of GHD-like symptoms. For adult GHD without pituitary disease, patient failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 PHD, low IGF-1 and failed one stimulation test. For renewal: patient has seen clinical improvement.
Age Restrictions	For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
Prescriber Restrictions	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Short stature homeobox-gene (SHOX) deficiency

ConnectiCare

HARVONI

Products Affected

- Harvoni oral tablet 90-400 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis. For patients with cirrhosis, cirrhosis must be documented by FibroScan, FibroTest ActiTest, liver biopsy, or radiological imaging.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	12 to 24 weeks, based on indication and current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the indication of Non-24-Hour Sleep-Wake Disorder (Non-24), approval will only be granted for patients who are totally blind.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

HRM

Products Affected

- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen oral tablet 50-325 mg
- butalbital-acetaminophen-caff oral capsule
- butalbital-acetaminophen-caff oral tablet 50-325-40 mg
- butalbital-aspirin-caffeine oral capsule
- clemastine oral tablet 2.68 mg
- cyclobenzaprine oral tablet
- cyproheptadine
- metaxalone
- methyldopa-hydrochlorothiazide
- promethazine oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

HRM - BENZODIAZEPINES

Products Affected

- alprazolam oral tablet extended release 24 hr
- lorazepam oral
- oxazepam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = 12 months
Other Criteria	All medically accepted indications other than insomnia, authorize use. Insomnia, approve lorazepam or oxazepam if the patient has had a trial with two of the following: ramelteon, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

HRM BENZODIAZEPINES/ANTICONVULSANTS

Products Affected

- clonazepam oral tablet,disintegrating
- clorazepate dipotassium
- diazepam oral concentrate
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

HRM PD

Products Affected

- amitriptyline
- clomipramine
- doxepin oral
- estradiol oral
- imipramine HCl
- imipramine pamoate
- megestrol oral tablet
- perphenazine-amitriptyline
- phenobarbital
- trimipramine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Start subcutaneous syringe kit 40 mg/0.8 mL, 40 mg/0.8 mL (6 pack)
- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira(CF)
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS
- HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	Crohn's disease (CD)- 6 years or older. Juvenile idiopathic arthritis (JIA), Uveitis - 2 years or older. Hidradenitis suppurativa (HS) - 12 years or older. Ulcerative colitis (UC), Ankylosing spondylitis (AS), Plaque psoriasis (PP), Psoriatic arthritis (PsA), Rheumatoid arthritis (RA) - 18 years and older.
Prescriber Restrictions	For RA, JIA, and AS, must be prescribed by, or in consultation with, a rheumatologist. For PsA, must be prescribed by, or in consultation with, a rheumatologist or dermatologist. For PP and HS, must be prescribed by, or in consultation with, a dermatologist. UC and CD, must be prescribed by, or in consultation with, a gastroenterologist. For UV, must be prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	3 years
Other Criteria	For RA, patient has tried one conventional synthetic DMARD for at least 3 months. Patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD. For JIA, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD) or will be starting on Humira concurrently with MTX, sulfasalazine, or leflunomide or if patient has aggressive disease. For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3

PA Criteria	Criteria Details
	months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. For CD, approve if patient has tried corticosteroids (CS) or if patient is currently on CS or if patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, infliximab, or ustekinumab) or patient had ilecolonic resection or enterocutaneous (perianal or abdominal) or rectovaginal fistulas. For UC, patient has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab or a corticosteroid such as prednisone or methylprednisolone) or was intolerant to one of these agents, or the patient has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. For HS, patient has tried one other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first. Clinical criteria incorporated into the Humira quantity limit edit, approve additional quantity (to allow for 40 mg every week) if the patient has a diagnosis of HS OR a diagnosis of RA in patients not receiving concomitant methotrexate.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HER2-negative, hormone receptor-positive, advanced or metastatic breast cancer
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For HER2-negative, hormone receptor-positive, advanced or metastatic breast cancer, must be used in combination with fulvestrant for progression following endocrine therapy OR in postmenopausal women or in men as initial therapy in combination with an aromatase inhibitor.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ICLUSIG

Products Affected

- Iclusig oral tablet 15 mg, 45 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	CML T315I-positive or has tried TWO other TKIs indicated for use in CML (e.g., imatinib, Sprycel, Tasigna). ALL Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. imatinib, Sprycel).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	Acute myeloid leukemia without the presence of the isocitrate dehydrogenase-2 (IDH2) mutation
Required Medical Information	Diagnosis, documentation of the presence of the isocitrate dehydrogenase-2 (IDH2) mutation in the blood or bone marrow as detected by an FDA-approved test
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For relapsed or refractory acute myeloid leukemia, patient has the isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

IMATINIB

Products Affected

- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed, 2) resistance or intolerance to prior therapy, or 3) recurrence after stem cell transplant. For ALL, patient meets one of the following: 1) newly diagnosed and imatinib is used in combination with chemotherapy, or 2) ALL is relapsed or refractory. For GIST, patient meets one of the following: 1) unresectable, recurrent, or metastatic disease, or 2) use of imatinib for adjuvant therapy following resection, or 3) use of imatinib for pre-operative therapy and patient is at risk for significant surgical morbidity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients with mantle cell lymphoma (MCL)-history of prior treatment. For patients with marginal zone lymphoma-history of prior treatment with at least one anti-CD20-based therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or a transplant specialist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

INGREZZA

Products Affected

- Ingrezza
- Ingrezza Initiation Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of moderate to severe tardive dyskinesia AND a history of current or previous chronic use of conventional neuroleptics, anticholinergics, toxins, substances of abuse, and other agents.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

INLYTA

Products Affected

- Inlyta oral tablet 1 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Advanced renal cell carcinoma, approve if the patient has failed at least one prior systemic therapy (eg, Torisel, Avastin, Sutent, IFN-alpha, IL-2, Votrient, Nexavar).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	3 years
Other Criteria	For primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF), approve if the patient has intermediate-2 or high-risk disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

IVIG

Products Affected

- Gammagard Liquid
- Gamunex-C injection solution 1 gram/10 mL (10 %)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pts home.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Steroid-refractory acute GVHD: 12 years or older. All other indications: 18 years or older.
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	3 years
Other Criteria	For polycythemia vera patients must have tried hydroxyurea
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

JYNARQUE

Products Affected

- Jynarque oral tablet
- Jynarque oral tablets, sequential

PA Criteria	Criteria Details
Exclusion Criteria	Pediatric patients less than 18 years of age, patients with uncorrected abnormal blood sodium concentrations.
Required Medical Information	Diagnosis, Serum sodium, ALT, AST and bilirubin laboratory results
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or a health care provider specializing in kidney health.
Coverage Duration	Initiation 3 months, Continuation 6 months
Other Criteria	For initiation, patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND is at risk of rapidly-progressing ADPKD. Patient has baseline serum sodium within the normal range. For continuation, patient has serum sodium laboratory results within the normal range.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Exclusion Criteria	Patients with cystic fibrosis who are homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	CF mutation test documenting one mutation in the CFTR gene.
Age Restrictions	6 months of age and older for packets. 6 years of age and older for tablets.
Prescriber Restrictions	Prescribed by or inconsultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Exclusion Criteria	Patient with history of hypersensitivity to diclorphenamide or other sulfonamides, Patient on high dose aspirin, Patient with severe pulmonary disease, Patient with hepatic insufficiency
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial therapy - 2 months, Continuing therapy - 12 months
Other Criteria	Hyperkalemic Periodic Paralysis (HyperPP) and Related Variants: Patient has a confirmed diagnosis of primary hyperkalemic periodic paralysis by meeting at least ONE of the following criteria: Patient has had an increase from baseline in serum potassium concentration of greater than or equal to 1.5 mEq/L during a paralytic attack OR Patient has had a serum potassium concentration during a paralytic attack of greater than 5.0 mEq/L OR Patient has a family history of the condition OR Patient has a genetically confirmed skeletal muscle sodium channel mutation AND The prescribing physician has excluded other reasons for acquired hyperkalemia (e.g., drug abuse, renal and adrenal dysfunction) For Continuation of treatment a patient has decrease in the frequency or severity of paralytic attacks with treatment as determined by the prescribing physician. For Hypokalemic Periodic Paralysis (HypoPP) and Related Variants for Initiation of treatment: Patient has a confirmed diagnosis of primary hypokalemic periodic paralysis by meeting at least ONE of the following: Patient has had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack OR Patient has a family history of the condition OR Patient has a genetically confirmed skeletal muscle calcium or sodium channel mutation AND Patient has had improvements in paralysis attack symptoms with potassium intake. For Continuation of treatment: Patient has decrease

PA Criteria	Criteria Details
	in the frequency or severity of paralytic attacks with treatment as determined by the prescribing physician
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

KISQALI

Products Affected

- Kisqali Femara Co-Pack oral tablet 200 mg/day(200 mg x 1)-2.5 mg, 400 mg/day(200 mg x 2)-2.5 mg, 600 mg/day(200 mg x 3)-2.5 mg
- Kisqali oral tablet 200 mg/day (200 mg x 1), 400 mg/day (200 mg x 2), 600 mg/day (200 mg x 3)

PA Criteria	Criteria Details
Exclusion Criteria	Use as monotherapy, pregnancy
Required Medical Information	Hormone receptor (HR) status, human epidermal growth factor receptor 2 (HER2) status, menopause status, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For pre/perimenopausal or postmenopausal women, patient has hormone-receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and Kisqali is being used in combination with an aromatase inhibitor as initial endocrine-based therapy. For postmenopausal women with HR-positive, HER-2 negative advanced or metastatic breast cancer, Kisqali (single agent) is being used in combination with fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy. Patients taking simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus. Concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

KUVAN

Products Affected

- Kuvan oral tablet,soluble

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Blood phenylalanine (Phe) levels. Pretreatment blood phenylalanine (Phe) levels greater than 10mg/dL if the patient is older than 12 years of age or greater than 6mg/dL if less than or equal to 12 years of age. Response to a therapeutic trial (greater than or equal to a 30% reduction in blood Phe levels) is required for long-term authorization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 months initial, 12 months on renewal
Other Criteria	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Differentiated Thyroid Cancer - must be locally recurrent or metastatic, progressive refractory to radioactive iodine treatment for approval. Advanced Renal Cell Carcinoma - must be used in combination with everolimus following one prior anti-angiogenic therapy (eg, Inlyta, Votrient, Sutent, Nexavar). For hepatocellular carcinoma (HCC), patient's disease is unresectable.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LEUKINE

Products Affected

- Leukine injection recon soln

PA Criteria	Criteria Details
Exclusion Criteria	Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule above established regimens. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle. For AML only, excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood.
Required Medical Information	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at risk of developing febrile neutropenia. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LEUPROLIDE

Products Affected

- Eligard
- Eligard (3 month)
- Eligard (4 month)
- Eligard (6 month)
- leuprolide subcutaneous kit
- Lupron Depot
- Lupron Depot (3 month)
- Lupron Depot (4 month)
- Lupron Depot (6 Month)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For abnrml uterine bleeding, uterine leiomyomata,endometriosis-6 mo.All other=12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

LIDOCAINE PATCH

Products Affected

- lidocaine topical adhesive patch,medicated

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For diabetic neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE medication that is FDA-labeled for diabetic peripheral neuropathy, including (but not limited to) duloxetine and Lyrica.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain, neuropathic pain associated with cancer

ConnectiCare

LINEZOLID

Products Affected

- linezolid
- linezolid in dextrose 5%

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Culture and sensitivity and CBC within normal limits
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LONG ACTING OPIOIDS

Products Affected

- KADIAN ORAL CAPSULE, EXTENDED RELEASE PELLETS 200 MG
- methadone oral solution 10 mg/5 mL, 5 mg/5 mL
- methadone oral tablet 10 mg, 5 mg
- morphine oral capsule, ER multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg
- morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- Nucynta ER
- oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	Acute (ie, non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis , not in long term care facility and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) at least two non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), unless unavailable in the state, AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is

PA Criteria	Criteria Details
	intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	Treatment-naive patients
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For Metastatic colorectal cancer, patient must have previously been treated with a fluoropyrimidine (e.g., capecitabine, 5-FU)-, AND oxaliplatin-, AND irinotecan based chemotherapy AND an anti-VEGF therapy AND if RAS wild-type, an anti-EGFR therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant treatment with strong CYP3A inducers.
Required Medical Information	Confirmed ALK-positive NSCLC as detected by an FDA-approved test, Previous therapies tried
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC), patient has metastatic ALK-positive NSCLC as detected by an FDA-approved test AND the patient has had disease progression on Xalkori (crizotinib) and at least one other ALK inhibitor for metastatic disease OR disease progression on Alecensa (alectinib) as the first ALK inhibitor therapy for metastatic disease OR disease progression on Zykadia (ceritinib) as the first ALK inhibitor therapy for metastatic disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LUCEMYRA

Products Affected

- Lucemyra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Medication history.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, a physician specializing in pain management or addiction psychiatry.
Coverage Duration	14 days
Other Criteria	Patient has a diagnosis of opioid dependence (physiologic dependence/tolerance) or opioid use disorder AND the patient is currently or will be undergoing abrupt opioid discontinuation AND Lucemyra is being used for mitigation of opioid withdrawal symptoms AND Lucemyra is being initiated during the period of peak withdrawal symptoms (i.e. the first 5 to 7 days following the last use of opioid) AND Lucemyra will only be used for up to 14 days.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

LYNPARZA

Products Affected

- Lynparza oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, A deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer as detected by an FDA-approved test.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	A documented diagnosis of advanced ovarian cancer which has been treated with at least three prior lines of chemotherapy. Maintenance treatment of recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, in patients who are in a complete or partial response to platinum-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

MEGESTROL

Products Affected

- megestrol oral suspension 400 mg/10 mL (40 mg/mL), 625 mg/5 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

MEKINIST

Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	For a diagnosis of melanoma, patients who have progressed on prior BRAF-inhibitor therapy
Required Medical Information	Documentation of the detected BRAFV600E or BRAFV600K mutation
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For Unresectable or metastatic, malignant melanoma, with BRAF V600E or V600K mutation, Mekinist will be used as monotherapy or in combination with Tafinlar. For the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, must be used in combination with Tafinlar following complete resection (with lymph node involvement). For metastatic NSCLC with BRAF V600E mutation, must be used in combination with Tafinlar. For locally advanced or metastatic anaplastic thyroid carcinoma with BRAF V600E mutation and no satisfactory locoregional treatment options, must be used in combination with Tafinlar.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF mutation status as detected by an FDA-approved test, current treatment regimen
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For melanoma, patient has unresectable or metastatic disease AND the presence of the BRAF V600E or V600K mutation as detected by an FDA-approved test AND patient has a left ventricular ejection fraction greater than or equal to 50% AND Mektovi will be used in combination with Braftovi.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

METHAMPHETAMINE

Products Affected

- methamphetamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

MODAFINIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be greater than or equal to 17 years of age.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Chart notes documenting scheduled procedure, Baseline platelet count
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or hematologist.
Coverage Duration	14 days
Other Criteria	For the treatment of thrombocytopenia, approve if patient has a diagnosis of chronic liver disease AND is scheduled to undergo an invasive procedure AND the patient has a documented baseline platelet count less than 50,000 taken within the last 14 days AND Mulpleta will be inititated 8 to 14 days prior to the procedure AND the procedure will occur 2 to 8 days following the last dose of Mulpleta AND Mulpleta is not being administered to normalize platelet counts.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	Hypoparathyroidism caused by calcium-sensing receptor mutations. Patients with acute post-surgical hypoparathyroidism.
Required Medical Information	Serum calcium level
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	Trastuzumab treatment naive patients, HER2-negative patients, ALT greater than 5-20 times the upper limit of normal, bilirubin greater than 3-10 times the upper limit of normal, concomitant use with proton pump inhibitors.
Required Medical Information	Diagnosis, human epidermal growth factor receptor 2 (HER2) status, previous therapies tried, patient has early stage breast cancer
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	12 months
Other Criteria	Nerlynx is being used for extended adjuvant treatment of early stage breast cancer with HER2 overexpression and patient has received adjuvant treatment with trastuzumab based therapy
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	3 years
Other Criteria	For locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC), patient must have history of refractory radioactive iodine treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NINLARO

Products Affected

- Ninlaro oral capsule 2.3 mg, 3 mg, 4 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous therapies tried and failed, baseline CBC
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For multiple myeloma, patient has received at least one prior therapy AND will be used in combination with lenalidomide and dexamethasone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis and prior medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	Initial 4 weeks, renewal 6 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinsons disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Patient has a diagnosis of non-metastatic castration resistant prostate cancer (nmCRPC) AND the patient must have a history of failure, intolerance, or contraindication to Xtandi AND Erleada.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

NUPLAZID

Products Affected

- Nuplazid oral capsule
- Nuplazid oral tablet 10 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

OCTREOTIDE

Products Affected

- octreotide acetate injection solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For locally advanced basal cell carcinoma (BCC) has recurred following surgery or radiation therapy or if the patient is not a candidate for surgery and the patient is not a candidate for radiation therapy, according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with pirfenidone
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in combination with a pulmonologist
Coverage Duration	3 years
Other Criteria	IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	12 months
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Opsumit or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Opsumit or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ORENCIA

Products Affected

- Orencia ClickJect
- Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	Juvenile idiopathic arthritis (JIA)- 2 years or older. Psoriatic arthritis (PsA), Rheumatoid arthritis (RA)- 18 years and older. Orencia ClickJect autoinjector- 18 years and older.
Prescriber Restrictions	For RA and JIA, must be prescribed by, or in consultation with, a rheumatologist. For PsA, must be prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	3 years
Other Criteria	For RA, patient has tried one conventional synthetic DMARD for at least 3 months. Patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD. For JIA, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD) or will be starting on Orencia concurrently with MTX, sulfasalazine, or leflunomide or if patient has aggressive disease. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ORILISSA

Products Affected

- Orilissa

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, Osteoporosis, Severe hepatic impairment (Child Pugh C), Concomitant use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors (e.g., cyclosporine and gemfibrozil).
Required Medical Information	Diagnosis, Child Pugh score
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an OBGYN.
Coverage Duration	Initiation (150 mg or 200 mg): 6 months. Continuation (150 mg Only): 18 months.
Other Criteria	For initiation of therapy, patient has moderate to severe pain associated with endometriosis. For continuation of therapy, patient is being treated with Orilissa 150 mg and does not have the following coexisting conditions (dyspareunia, moderate hepatic impairment [Child Pugh Class B]). Maximum treatment duration 150 mg: 24 months, 200 mg: 6 months.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried.
Age Restrictions	18 years and older
Prescriber Restrictions	For Psoriatic Arthritis (PsA), must be prescribed by, or in consultation with, a dermatologist or rheumatologist. For Plaque psoriasis (PP), must be prescribed by, or in consultation with, a dermatologist.
Coverage Duration	3 years
Other Criteria	For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried, the request specifies the affected eye(s) intended for treatment
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	8 weeks
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PENICILLAMINE

Products Affected

- Depen Titratabs
- penicillamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PHENOXYBENZAMINE

Products Affected

- phenoxybenzamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PIQRAY

Products Affected

- Piqray oral tablet 200 mg/day (200 mg x 1), 250 mg/day (200 mg x1-50 mg x1), 300 mg/day (150 mg x 2)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HER2-negative, hormone receptor-positive, advanced or metastatic breast cancer. Documentation of PIK3CA-mutation as detected by an FDA-approved test. Previous therapies tried. Current therapy regimen.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For the treatment of postmenopausal women, or in men, patient has hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer following progression on or after an endocrine-based regimen AND Piqray is being used in combination with fulvestrant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis, prior therapies, for female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Pomalyst.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	3 years
Other Criteria	For multiple myeloma must be used in combination with dexamethasone and patient has received at least two prior therapies including lenalidomide and a proteasome inhibitor and has demonstrated disease progression on or within 60 days of completion of the last therapy. Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Pomalyst use. Patients should be monitored for signs and symptoms of thromboembolism.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PRALUENT

Products Affected

- Praluent Pen subcutaneous pen injector
  150 mg/mL, 75 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Praluent with Repatha, Juxtapid or Kynamro.
Required Medical Information	Current LDL-C (within the past 90 days), prior therapies tried, medication adverse event history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	3 years
Other Criteria	Hyperlipidemia in pts w/ (ASCVD) apprv if the pt has a curr LDL-C lvl of grtr or eq to 70 mg/dL w/in the past 90 ds (after tx with antihyperlipidemic agnts but prior to PCSK9 inh tx such as Praluent or Repatha) AND the pt has had one of the following conds or dxs: prev MI,OR has a hx of an acute coronary syndrome, OR The pt has a dx of angina (stable or unstable) ,OR The pt has a past hx of stroke or TIA, OR The pt has PAD, The pt has undergone a coronary or other arterial revascularization procedure AND The pt has tried 1 high-intensity statin tx (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks AND the LDL-C lvl remains equal or more than70 mg/dL unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Praluent tx. Heterozygous Familial Hypercholesterolemia apprve if the pt has a curnt LDL-C lvl eq or more than 100 mg/dL w/in the past 30 days, AND the pts dx of HeFH is def as probable or definite by WHO/Dutch Lipid grp criteria OR definite by Simon-Broome Criteria OR genetic testing, AND The pt has tried 1 high-intensity statin txs (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12

PA Criteria	Criteria Details
	cont wks, AND the LDL-C lvl remains eq or more than 100 mg/dL, unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Praluent tx.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PREVYMIS

Products Affected

- Prevymis oral

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with pimozide, ergot alkaloids (e.g. ergotamine, dihydroergotamine), concurrent use with either pitavastatin or simvastatin when letermovir is being used in combination with cyclosporine, initiation of therapy after day 28 following transplant, treatment beyond day 100 following transplant
Required Medical Information	Diagnosis, patient has received allogeneic hematopoietic stem cell transplant (HSCT), the HSCT procedure date, confirmation that patient is CMV-seropositive
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a physician who specializes in infectious disease, hematology, oncology or transplant specialist.
Coverage Duration	100 days
Other Criteria	For the prophylaxis of CMV infection and disease, patient is CMV seropositive, patient has received an HSCT, and therapy is being initiated between day 0 and day 28 following transplant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PROCRIT/RETACRIT

Products Affected

- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL
- Retacrit injection solution 10,000 unit/mL, 2,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	CRF anemia in patients on and not on dialysis. Hemoglobin (Hb) of less than 10.0 g/dL to start. Hb less than or equal to 10 g/dL for adults (CKD, not on dialysis), 11 g/dL (CKD on dialysis) or 12 g/dL or less for pediatric CKD. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb less than or equal to 10.0 g/dL. MDS, approve if Hb is 10 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia/HepC anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist. Hep C anemia, prescribed by or in consultation with hepatologist, gastroenterologist, hematologist or infectious disease physician who specializes in the management of hepatitis C.
Coverage Duration	Anemia w/myelosuppress = 4 mos.Transfus=1 mo.Other= 6mo. HIV + zidovudine = 4 mo
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Miacalcin, Fortical]), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass), approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphospohate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has multiple osteoporotic fractures. Treatment of bone loss in men at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer, approve if the patient has breast cancer that is not metastatic to the bone and is receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of glucocorticoid induced osteoporosis (GIO), approve if: pt is initiating or continuing therapy with systemic

PA Criteria	Criteria Details
	glucocorticoids, AND has had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PROMACTA

Products Affected

- Promacta oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS). Use in combination with Nplate for treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura.
Required Medical Information	Cause of thrombocytopenia.
Age Restrictions	N/A
Prescriber Restrictions	Treatment of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP), approve if prescribed by, or after consultation with, a hematologist. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, either a hematologist, gastroenterologist, a hepatologist, or a physician who specializes in infectious disease.
Coverage Duration	12 months
Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried corticosteroids or IVIG or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy .
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

QUININE

Products Affected

- quinine sulfate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Exclusion Criteria	Patients with known neoplasm(s) at the site(s) of application. The treatment of pressure ulcers, venous stasis ulcers, diabetic neuropathic ulcers that do not extend through the dermis into subcutaneous tissue [Stage I or II, International Association of Enterostomal Therapy (IAET) staging classification] or ischemic diabetic ulcers.
Required Medical Information	Diagnosis, Wound type, Wound location, Current treatment regimen
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	For lower extremity diabetic neuropathic ulcers, wounds must extend into the subcutaneous tissue or beyond and have an adequate blood supply. Treatment with Regranex must be used as an adjunct to, and not a substitute for, good ulcer care practices including initial sharp debridement, pressure relief and infection control.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Repatha with Praluent, Juxtapid or Kynamro
Required Medical Information	Current LDL-C (within the past 90 days), prior therapies tried, medication adverse event history
Age Restrictions	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	3 years
Other Criteria	Hyperlipidemia in pts w/ (ASCVD) apprv if the pt has a curr LDL-C lvl of grtr or eq to 70 mg/dL w/in the past 90 ds (after tx with antihyperlipidemic agnts but prior to PCSK9 inh tx such as Praluent or Repatha) AND the pt has had one of the following conds or dxs: prev MI,OR has a hx of an acute coronary syndrome, OR The pt has a dx of angina (stable or unstable) ,OR The pt has a past hx of stroke or TIA, OR The pt has PAD, The pt has undergone a coronary or other arterial revascularization procedure AND The pt has tried 1 high-intensity statin tx (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks AND the LDL-C lvl remains equal or more than70 mg/dL unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx. Heterozygous Familial Hypercholesterolemia apprve if the pt has a curnt LDL-C lvl eq or more than 100 mg/dL w/in the past 30 days, AND the pts dx of HeFH is def as probable or definite by WHO/Dutch Lipid grp criteria OR definite by Simon-Broome Criteria OR genetic testing, AND The pt has tried 1 high-intensity statin txs (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12

PA Criteria	Criteria Details
	cont wks, AND the LDL-C lvl remains eq or more than 100 mg/dL, unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx. Primary hyperlipidemia apprve if the pt has a curnt LDL-C lvl eq or more than 100 mg/dL w/in the past 90 days, AND The pt has tried 1 high-intensity statin txs (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks, AND the LDL-C lvl remains eq or more than 100 mg/dL, unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	For active myeloma patient meets one of the following: 1) Revlimid is used in combination with dexamethasone. 2) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For mantle cell lymphoma (MCL): Revlimid is used after 2 prior therapies, 1 of which is bortezomib. For Low or Intermediate-1 Risk myelodysplastic syndrome (MDS): for those with 5q deletion, patients should have transfusion-dependent anemia or symptomatic anemia with clinically significant cytopenias. For those with non-5q deletion MDS and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin or have a pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Revlimid.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Prior therapies, documentation of the presence of a deleterious BRCA mutation (germline and/or somatic)
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with Oncologist
Coverage Duration	3 years
Other Criteria	Patient selection must be based on an FDA-approved companion diagnostic. Patient must have been treated with two or more chemotherapies prior to Rubraca. Rubraca must be used as monotherapy. For maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, patient has had a complete or partial response to platinum-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	For AML, use as monotherapy for the treatment of patients with AML and patients with FLT3-mutation negative disease, Pediatric patients
Required Medical Information	Diagnosis, for AML, patients must have the FLT3-mutation, as detected by an FDA approved test
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	3 years
Other Criteria	For AML, patient is newly diagnosed, AND Rydapt will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation therapy AND the patient has FLT3-mutation positive AML as detected by an FDA approved test AND patient is receiving Rydapt on days 8-21 of each cycle of induction with cytarabine and daunorubicin and on days 8-21 of each cycle of consolidation with high-dose cytarabine
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SAMSCA

Products Affected

- Samsca oral tablet 15 mg, 30 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Signifor is being used.
Age Restrictions	Cushing's, 18 years of age and older.
Prescriber Restrictions	Initial course, prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial therapy, approve for 3 months. Continuation therapy, approve for 12 months
Other Criteria	Cushing's disease, approve if according to the prescribing physician the patient is not a candidate for surgery or surgery has not been curative. Patients who have already been started on Signifor for Cushing's disease will be approved if the patient has had a response, as determined by the prescribing physician and the patient is continuing therapy to maintain response.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SILDENAFIL - PAH

Products Affected

- sildenafil (Pulmonary Arterial Hypertension) oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Nitrate therapy
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SKYRIZI

Products Affected

- Skyrizi subcutaneous syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	For Plaque psoriasis (PP), must be prescribed by, or in consultation with, a dermatologist.
Coverage Duration	3 years
Other Criteria	For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. Clinical criteria incorporated into the Skyrizi quantity limit edit, approve additional quantity (to allow for loading doses at week 0 and week 4 then every 12 weeks thereafter).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SPRYCEL

Products Affected

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL) and newly diagnosed chronic myeloid leukemia (CML) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance or intolerance to imatinib, or 3) relapse after stem cell transplant. For ALL, resistance or intolerance to prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

STELARA

Products Affected

- Stelara subcutaneous solution
- Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	Plaque psoriasis (PP)- 12 years and older. Crohn's disease (CD) and Psoriatic arthritis (PsA)- 18 years and older.
Prescriber Restrictions	For PP, must be prescribed by, or in consultation with, a dermatologist. For PsA, must be prescribed by, or in consultation with, a rheumatologist or dermatologist. For CD, must be prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	3 years
Other Criteria	For PP, approve if the patient has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. Patients who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first. or CD, approve if patient has tried corticosteroids (CS) or if patient is currently on CS or if patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, infliximab, or adalimumab) or patient had ilecolonic resection or enterocutaneous (perianal or abdominal) or rectovaginal fistulas AND patient has received a single IV loading dose. Clinical criteria incorporated into the Stelara 90 mg quantity limit edit, approve additional quantity (to allow for 90 mg every 8 weeks) if the patient has a diagnosis of CD. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. For metastatic colorectal cancer (CRC)and gastrointestinal stromal tumors (GIST), prior therapies tried. For metastatic CRC, KRAS mutation status.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For metastatic CRC with KRAS mutation, patient must have been treated with ALL of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan, anti-VEGF therapy (eg, Avastin, Zaltrap). For metastatic CRC with no detected KRAS mutation (KRAS wild-type), patient must ALSO have been treated with an anti-EGFR therapy (eg, Eribitux, Vectibix). For GIST, patient must have previously been treated with imatinib and sunitinib (Sutent). For Liver carcinoma, patient must have been previously treated with sorafenib (Nexavar).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Exclusion Criteria	Clinical manifestations of congestive heart failure.
Required Medical Information	Diagnosis, prior therapies, For gastrointestinal stromal tumor (GIST), disease progression while on an at least 30-day regimen of imatinib or intolerance to imatinib is required.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	Therapy will be interrupted for serious hepatic adverse events and discontinued if serious hepatic adverse events do not resolve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Orkambi or Kalydeco.
Required Medical Information	Diagnosis, Cystic Fibrosis Transmembrane Regulator (CFTR) gene mutation, Current medication regimen
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis (CF).
Coverage Duration	3 years
Other Criteria	For Cystic Fibrosis, patient must have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A G, S945L, S977F, F1052V, E831X, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G A, 3272-26A G, or 3849 + 10kbC T OR the patient has two copies of the F508del mutation.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, current treatment regimen, previous therapies tried
Age Restrictions	2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of Lennox-Gastaut syndrome (LGS) AND the patient is concomitantly receiving ONE other antiepileptic drug specifically for the treatment of LGS (e.g., lamotrigine, topiramate, felbamate) AND the patient has had a trial of clobazam unless contraindicated (e.g., oral or motor difficulties, dysphagia).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TADALAFIL - BPH

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Indication for which tadalafil is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED) and after a trial of an alpha-1 blocker (eg, doxazosin [Cardura XL], terazosin, tamsulosin [Flomax], alfuzosin extended-release [UroXatral]) or 5 alpha reductase inhibitor (eg, finasteride, dutasteride [Avodart]).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TADALAFIL - PAH

Products Affected

- Alyq
- tadalafil (pulm. hypertension)

PA Criteria	Criteria Details
Exclusion Criteria	Nitrate therapy
Required Medical Information	PAH has been confirmed by right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Documentation of the detected BRAF V600E or V600K mutations
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For unresectable or metastatic melanoma with BRAF V600K mutation, must be used in combination with Mekinist. For metastatic NSCLC with BRAF V600E mutation, must be used in combination with Mekinist. For locally advanced or metastatic anaplastic thyroid carcinoma with BRAF V600E mutation and no satisfactory locoregional treatment options, must be used in combination with Mekinist.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	For EGFR T790M mutation-positive NSCLC, tyrosine kinase inhibitor treatment naive patients.
Required Medical Information	Confirmed T790M mutation-positive OR EGFR exon 19 deletions or exon 21 (L858R) substitution mutation positive NSCLC as detected by an FDA approved test. For T790M mutation-positive NSCLC, prior therapies tried.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	The patient has metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an FDA approved test AND The patient has progressed on or after one of Tarceva (erlotinib tablets), Iressa (gefitinib tablets), or Gilotrif (afatinib tablets) therapy. Approve if the patient has metastatic NSCLC, whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TALZENNA

Products Affected

- Talzenna oral capsule 0.25 mg, 1 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, documentation of the presence of germline BRCA mutation, Human epidermal growth factor receptor 2 (HER2) status.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For locally advanced or metastatic breast cancer, patient has germline BRCA mutation-positive breast cancer AND patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TARCEVA

Products Affected

- erlotinib oral tablet 100 mg, 150 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For 1st line therapy of locally advanced or metastatic NSCLC, patient should have a known active EGFR exon 19 deletions or exon 21 substitution mutation or amplification of the EGFR gene.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For first line treatment of locally advanced, unresectable, or metastatic pancreatic cancer, erlotinib must be used in combination with gemcitabine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TASIGNA

Products Affected

- Tasigna oral capsule 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	Long QT syndrome, uncorrected electrolyte disorders (hypokalemia, hypomagnesemia). Concomitant use with drugs known to prolong the QT interval and strong CYP3A4 inhibitors.
Required Medical Information	Diagnosis, prior therapies tried, Philadelphia chromosome or BCR-ABL gene status, stage of disease (accelerated, chronic).
Age Restrictions	1 year of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	12 months
Other Criteria	For adult and pediatric patients with newly diagnosed CML, approve if the patient has Philadelphia chromosome-positive CML in chronic phase. For adult patients with resistant or intolerant CML, approve if the patient has Philadelphia chromosome positive CML in chronic or accelerated phase AND patient has resistance or intolerance to prior therapy that included imatinib. For pediatric patients with resistant or intolerant CML, approve if the patient has Philadelphia chromosome positive CML in chronic phase AND patient has resistance or intolerance to prior tyrosine-kinase inhibitor therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Exclusion Criteria	Patients with a platelet count below 100 x 109/L. Patients with a history of acute glomerulonephritis caused by Tegsedi.
Required Medical Information	Diagnosis. Documented transthyretin (TTR) mutation verified by genetic testing. Medical history.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis.
Coverage Duration	12 months
Other Criteria	The patient has a documented diagnosis of Polyneuropathy of Hereditary Transthyretin Mediated Amyloidosis (hATTR) AND the patient has a documented transthyretin (TTR) mutation (e.g.,V30M) verified by genetic testing AND the patient has symptomatic peripheral neuropathy (e.g., reduced motor strength/ coordination, impaired sensation [e.g., pain, temperature, vibration, touch]).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TETRABENAZINE

Products Affected

- tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

THALOMID

Products Affected

- Thalomid oral capsule 100 mg, 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	For active myeloma, patient meets one of the following: 1) Thalomid is used as salvage or palliative therapy. 2) Thalomid is used for newly diagnosed disease or as primary induction therapy in combination with dexamethasone or in combination with melphalan and prednisone in nontransplant candidates. 3) Thalomid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For female patients of childbearing potential, pregnancy is excluded by a negative pregnancy test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Patients are monitored for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential are instructed on the importance of proper utilization of appropriate contraceptive methods.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	Acute myeloid leukemia without the presence of the isocitrate dehydrogenase-1 (IDH1) mutation
Required Medical Information	Diagnosis. For relapsed or refractory AML, previous therapies tried. Documentation of the presence of the isocitrate dehydrogenase-1 (IDH1) mutation in the blood or bone marrow as detected by an FDA-approved test.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For relapsed or refractory acute myeloid leukemia, patient has the isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test. For newly-diagnosed acute myeloid leukemia, patient has a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test AND the patient is at least 75 years old OR according to the prescribing physician, the patient has comorbidities that preclude the use of intensive induction chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TIRF MEDICATIONS

Products Affected

- fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TOLSURA

Products Affected

- Tolsura

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of onychomycosis, patients with known hypersensitivity to itraconazole.
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For approval of Tolsura, patient has a documented diagnosis of histoplasmosis, pulmonary or extrapulmonary blastomycosis OR pulmonary or extrapulmonary aspergillosis AND patient has had a trial and documented therapeutic failure with generic itraconazole 100 mg tablets AND if the diagnosis is aspergillosis, patient must also have had an intolerance to or treatment failure with amphotericin B.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TRACLEER

Products Affected

- bosentan
- Tracleer oral tablet for suspension

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	12 months
Other Criteria	For pulmonary arterial hypertension (PAH) WHO Group 1, patients not currently on bosentan or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on bosentan or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization. For CTEPH, patient must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic thromboembolic pulmonary hypertension (CTEPH)

ConnectiCare

TRANSDERMAL FENTANYL

Products Affected

- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis , not in long term care facility and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), unless unavailable in the state, AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescribing physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TRETINOIN

Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene topical solution
- tretinoin microspheres topical gel
- tretinoin topical cream
- tretinoin topical gel 0.01 %, 0.025 %

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ConnectiCare

TRIENTINE

Products Affected

- trientine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For Wilson's disease, patient must have history of intolerance, failure or contraindication to penicillamine (i.e., Cuprimine or Depen).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Liver function tests must be monitored at baseline and every four to six weeks during therapy and as clinically indicated. In patients with severe hepatic impairment, Tykerb is used at a reduced dose.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For advanced or metastatic breast cancer with HER2 overexpression, Tykerb must be used in combination with capecitabine after previous treatment with an anthracycline, a taxane, and trastuzumab. For breast cancer in postmenopausal women with HER2 overexpression, Tykerb must be used in combination with letrozole.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

UPTRAVI

Products Affected

- Uptravi oral tablet
- Uptravi oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	Breast feeding mother, severe hepatic impairment (Child-Pugh Class C)
Required Medical Information	prior treatments
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is NOT required in pts who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Patient must have previously tried or is currently taking at least one other agent indicated for PAH treatment (eg, sildenafil, Adcirca, Revatio, Tracleer, Letairis Opsumit, Adempas, Orenitram, Tyvaso, Ventavis, Remodulin, or epoprostenol injection).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Past medical history
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consulation with, an oncologist.
Coverage Duration	12 months
Other Criteria	For Stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma, patients must have received prior skin-directed therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VENCLEXTA

Products Affected

- Venclexta oral tablet 10 mg, 100 mg, 50 mg
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy, medical history, current medication regimen
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), approve. For newly diagnosed AML, approve if the patient is using Venclexta in combination with azacitidine, decitabine, or low-dose cytarabine AND the patient is 75 years of age or older OR according to the prescribing physician, the patient has comorbidities that preclude the use of intensive induction chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	For monotherapy, patients without prior endocrine therapy and prior chemotherapy, In combination with fulvestrant, patients without prior endocrine therapy.
Required Medical Information	Estrogen receptor (ER) status, Human epidermal growth factor receptor 2 (HER2) status, Previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For advanced (metastatic) breast cancer, patient has estrogen receptor-positive (ER+), HER2 negative breast cancer and will be using Verzenio in combination with an aromatase inhibitor as initial endocrine-based therapy and is postmenopausal OR patient had disease progression following endocrine therapy (e.g. anastrozole, letrozole, exemastane, tamoxifen) and will be receiving Verzenio in combination with fulvestrant OR patient had disease progression following endocrine therapy (e.g. anastrozole, letrozole, exemastane, tamoxifen) AND prior chemotherapy and will be receiving Verzenio as monotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VIGABATRIN

Products Affected

- vigabatrin

PA Criteria	Criteria Details
Exclusion Criteria	Patients with or at high risk of vision loss (except patients who have blindness). Patients using other medications associated with serious adverse ophthalmic effects such as retinopathy or glaucoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Infantile spasms: initial 4 wks, reauth 6 mths. CPS: initial 3 mths, reauth for 12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VIMPAT

Products Affected

- Vimpat oral solution
- Vimpat oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	4 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VITRAKVI

Products Affected

- Vitrakvi oral capsule 100 mg, 25 mg
- Vitrakvi oral solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Presence of a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, Previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	The patient has a solid tumor that has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic OR surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments OR the patient has disease progression following treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Confirmation of epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	For metastatic non-small cell lung cancer (NSCLC), patient has the presence of EGFR exon 19 deletion or exon 21 (L858R) substitution mutation as detected by an FDA-approved test AND Vizimpro is being used as first-line treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	Alanine transaminase (ALT) greater than 3 times the upper limit of normal (ULN) and bilirubin greater than 2 times the ULN.
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	For advanced soft tissue sarcoma, patients must have received prior chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VRAYLAR

Products Affected

- Vraylar oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg
- Vraylar oral capsule,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with Onpattro or Tegsedi. Concurrent use of Vyndaqel and Vyndamax.
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis.
Coverage Duration	12 months
Other Criteria	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis- approve if the patient meets all of the following: patient has genetic testing to identify a transthyretin (TTR) mutation (e.g., Val122Ile mutation, Thr60Ala mutation) or wild-type amyloidosis AND diagnosis was confirmed by one of the following (i or ii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy) OR ii. Amyloid deposits are identified on cardiac biopsy AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status required. ROS1 Status
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	NSCLC, patient must have a tumor that is ALK-positive or ROS1-positive for approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Exclusion Criteria	Adult patients. For ALL, use as monotherapy. For pJIA, first-line therapy. Pregnancy.
Required Medical Information	Diagnosis. For pJIA, prior therapies. For ALL, concurrent use of other chemotherapy
Age Restrictions	Pediatric patients under 18 years of age
Prescriber Restrictions	For ALL, prescribed by or in consultation with an oncologist. For pJIA, prescribed by or in consultation with a rheumatologist
Coverage Duration	12 months
Other Criteria	For ALL, Xatmep is used as part of a combination chemotherapy maintenance regimen. For pJIA, patient had an insufficient response or intolerance to first-line therapy, including full-dose NSAIDs. Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is for a cancer diagnosis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, etanercept, adalimumab, infliximab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	18 years and older
Prescriber Restrictions	For Rheumatoid arthritis (RA), must be prescribed by or in consultation with a rheumatologist. For Psoriatic Arthritis (PsA), must be prescribed by, or in consultation with, a dermatologist or rheumatologist. For Ulcerative Colitis (UC), must be prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	3 years
Other Criteria	For RA, patient has tried one conventional synthetic DMARD for at least 3 months. Patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD. For UC, approve Xeljanz (not XR) if the patient has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab or a corticosteroid such as prednisone or methylprednisolone) or was intolerant to one of these agents, or the patient has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. For PsA, patient has tried at least one conventional systemic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant. Patients who have already tried a biologic are not required to step back and try a conventional DMARD first.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	Treatment naive patients, use as a monotherapy
Required Medical Information	Diagnosis, previous therapies tried with dates of treatment, chart notes documenting number of bowel movements per day
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or gastroenterologist
Coverage Duration	Initiation - 12 weeks, Continuation - 12 months
Other Criteria	For initiation for carcinoid syndrome diarrhea, the patient has been on a long-acting somatostatin analog (SSA) therapy (e.g. Somatuline Depot [lanreotide for injection], octreotide injection) for at least 3 months and while on long-acting somatostatin analog therapy (prior to starting Xermelo) the patient continues to have at least four bowel movements per day and iii. Xermelo will be used in combination with a long-acting somatostatin analog therapy. For continuation for carcinoid syndrome diarrhea, the patient has experienced a decrease in the number of bowel movements per day and the patient continues to take Xermelo in combination with a long-acting somatostatin analog therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XOLAIR

Products Affected

- Xolair subcutaneous recon soln
- Xolair subcutaneous syringe 150 mg/mL, 75 mg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	Body weight greater than 150 kg.
Required Medical Information	For IgE-mediated allergic asthma: for patients 12 years of age and older, pre-treatment serum IgE level greater than or equal to 30 IU/mL to less than or equal to 700 IU/mL and patient's body weight. For IgE-mediated allergic asthma: for patients 6 to less than 12 years of age, pre-treatment serum IgE level greater than or equal to 30 IU/mL to less than or equal to 1,300 IU/mL and patient's body weight. For CIU - must have urticaria for more than 6 weeks, with symptoms present more than 3 days per week despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND must have tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	12 months
Other Criteria	Moderate to severe persistent asthma must meet all criteria patient's asthma symptoms have not been adequately controlled by concomitant use of at least 3 months of inhaled corticosteroid and a long-acting beta-agonist (LABA) or LABA alternative, if LABA contraindicated or patient has intolerance then alternatives include sustained-release theophylline or a leukotriene modifier (eg, montelukast), AND inadequate control demonstrated by hospitalization for asthma, requirement for systemic corticosteroids to control asthma exacerbation(s), or increasing need (eg, more than 4 times a day) for short-acting inhaled beta2 agonists for symptoms (excluding preventative use for exercise-induced asthma).
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

ConnectiCare

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to gilteritinib or any of the excipients.
Required Medical Information	Diagnosis, patients must have the FLT3-mutation, as detected by an FDA approved test
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML) AND the patient has FLT3-mutation positive AML as detected by an FDA-approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XPOVIO

Products Affected

- Xpovio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. Previous therapies tried. Current therapy regimen.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For relapsed or refractory multiple myeloma (RRMM), patient has received at least four prior therapies AND the disease is refractory to at least two proteasome inhibitors (e.g. Ninlaro), at least two immunomodulatory agents (e.g. Pomalyst, Revlimid), AND an anti-CD38 monoclonal antibody AND Xpovio will be used in combination with dexamethasone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	Patients being treated with sedative hypnotic agents, the use of alcohol, patients with succinic semialdehyde dehydrogenase deficiency
Required Medical Information	Diagnosis, past medical history, current medication regimens
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by, or in consulation with, a neurologist or sleep specialist.
Coverage Duration	12 months
Other Criteria	For excessive daytime sleepiness (EDS) in patients with narcolepsy, patient must have a trial and failure, contraindication, or intolerance to one CNS stimulant drug (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine) OR one CNS wakefulness promoting drug (e.g. armodafinil).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	Patients with a history of serious allergic reactions to filgrastim or pegfilgrastim products. Administration within 24 hours preceding or following chemotherapy or radiotherapy.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	For cancer patients receiving chemotherapy, the patient must be receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen) OR the patient must be receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen AND the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (e.g., at least 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, HIV infection) OR the patient must have had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a CSF (e.g., filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment OR the patient has received chemotherapy, has febrile neutropenia, and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescribing physician (e.g., sepsis syndrome, older than 65 years, severe neutropenia - ANC less than 100 cells/mm3, neutropenia expected to be more than 10 days in duration,

PA Criteria	Criteria Details
	invasive fungal infection, other clinically documented infections, or prior episode of febrile neutropenia).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, confirmed complete or partial response to platinum-based chemotherapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	3 years
Other Criteria	For ovarian cancer, patient has had a complete or partial response to platinum-based chemotherapy AND Zejula therapy is to begin within 8 weeks after the most recent platinum-containing regimen
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of melanoma, for patients new to therapy, BRAFV600E status required.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	3 years
Other Criteria	Melanoma, patient new to therapy must have BRAFV600E mutation for approval. For Erdheim-Chester Disease (ECD), approve if BRAF V600 mutation has been detected by an FDA approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried, current therapy regimen
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consulation with, an oncologist.
Coverage Duration	12 months
Other Criteria	For the treatment of cutaneous manifestations of cutaneous T-cell lymphoma, patient has progressive, persistent, or recurrent disease on or following two systemic therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of AST/ALT less than 20 x ULN and Bilirubin less than 10 x ULN, history of previous therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For relapsed chronic lymphoid leukemia, Zydelig must be used in combination with rituximab. For Follicular, B-cell, relapsed Non-Hodgkin's lymphoma, patient must have previous history of at least 2 prior therapies. For relapsed small lymphocytic lymphoma, patient must have previous history of at least 2 prior therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

ZYKADIA

Products Affected

- Zykadia oral capsule
- Zykadia oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	3 years
Other Criteria	For metastatic non-small cell lung cancer that is anaplastic lymphoma kinase positive, patient must have progressed or be intolerant to crizotinib for approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ConnectiCare

PART B VERSUS PART D

Products Affected

- Abelcet intravenous suspension
- acetylcysteine solution
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL
- AmBisome intravenous suspension for reconstitution
- amikacin injection solution 500 mg/2 mL
- Aminosyn II 10 % intravenous parenteral solution
- Aminosyn II 15 % intravenous parenteral solution
- Aminosyn-PF 10 % intravenous parenteral solution
- Aminosyn-PF 7 % Sulfite Free intravenous parenteral solution
- amphotericin B injection recon soln
- ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg
- ampicillin-sulbactam injection recon soln
- aprepitant oral capsule
- aprepitant oral capsule,dose pack
- Aralast NP intravenous recon soln 1,000 mg
- Astagraf XL oral capsule,extended release 24hr
- Azasan oral tablet
- azathioprine oral tablet
- azithromycin intravenous recon soln
- BCG vaccine, live (PF) percutaneous suspension for reconstitution
- budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- calcitriol oral capsule
- calcitriol oral solution
- caspofungin intravenous recon soln
- cefazolin injection recon soln 10 gram
- cefepime injection recon soln
- cefoxitin intravenous recon soln
- ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg
- cefuroxime sodium injection recon soln 750 mg
- cefuroxime sodium intravenous recon soln
- cinacalcet oral tablet 30 mg, 60 mg, 90 mg
- clindamycin phosphate injection solution
- clindamycin phosphate intravenous solution 600 mg/4 mL
- CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION
- Clinimix 4.25%/D10W Sulfite Free intravenous parenteral solution
- Clinimix 4.25%/D5W Sulfite Free intravenous parenteral solution
- Clinimix 5%-D20W Sulfite Free intravenous parenteral solution
- Clinimix E 2.75%/D5W Sulfite Free intravenous parenteral solution
- Clinimix E 4.25%/D10W Sulfite Free intravenous parenteral solution
- Clinimix E 4.25%/D5W Sulfite Free intravenous parenteral solution
- Clinimix E 5%/D15W Sulfite Free intravenous parenteral solution
- Clinimix E 5%/D20W Sulfite Free intravenous parenteral solution
- colistin (colistimethate Na) injection recon soln
- cromolyn inhalation solution for nebulization
- cyclophosphamide oral capsule
- cyclosporine modified oral capsule
- cyclosporine modified oral solution
- cyclosporine oral capsule
- D2.5 %-0.45 % sodium chloride intravenous parenteral solution
- D5 % and 0.9 % sodium chloride intravenous parenteral solution
- D5 %-0.45 % sodium chloride intravenous parenteral solution

- Depo-Provera intramuscular suspension 400 mg/mL
- dextrose 10 % and 0.2 % NaCl intravenous parenteral solution
- dextrose 10 % in water (D10W) intravenous parenteral solution
- dextrose 5 % in water (D5W) intravenous parenteral solution
- dextrose 5%-0.2 % sod chloride intravenous parenteral solution
- dextrose 5%-0.3 % sod.chloride intravenous parenteral solution
- Dextrose With Sodium Chloride intravenous parenteral solution
- dronabinol oral capsule
- Emend oral suspension for reconstitution
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular syringe
- Envarsus XR oral tablet extended release 24 hr
- Erythrocin intravenous recon soln 500 mg
- fluconazole in NaCl (iso-osm) intravenous piggyback 200 mg/100 mL, 400 mg/200 mL
- furosemide injection syringe
- Gammagard S-D (IgA < 1 mcg/mL) intravenous recon soln
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution
- gentamicin injection solution 40 mg/mL
- granisetron HCl oral tablet
- heparin (porcine) injection solution
- Hepatamine 8% intravenous parenteral solution
- hydromorphone (PF) injection solution 10 (mg/mL) (5 ml), 10 mg/mL
- imipenem-cilastatin intravenous recon soln
- Increlex subcutaneous solution
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- Intron A injection recon soln
- Intron A injection solution
- ipratropium bromide inhalation solution
- ipratropium-albuterol inhalation solution for nebulization
- levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL, 1.25 mg/3 mL
- levocarnitine (with sugar) oral solution
- levocarnitine oral tablet
- levofloxacin intravenous solution
- magnesium sulfate injection solution
- magnesium sulfate injection syringe
- meropenem intravenous recon soln
- methotrexate sodium (PF) injection solution
- methotrexate sodium injection solution
- methotrexate sodium oral tablet
- morphine injection syringe 10 mg/mL
- morphine intravenous syringe 8 mg/mL
- moxifloxacin-sod.chloride(iso) intravenous piggyback
- mycophenolate mofetil oral capsule
- mycophenolate mofetil oral suspension for reconstitution
- mycophenolate mofetil oral tablet
- mycophenolate sodium oral tablet,delayed release (DR/EC)
- nafcillin injection recon soln
- Nebupent inhalation recon soln
- Nephramine 5.4 % intravenous parenteral solution
- Normosol-M in 5 % dextrose intravenous parenteral solution
- Normosol-R in 5 % dextrose intravenous parenteral solution
- Normosol-R pH 7.4 intravenous parenteral solution
- ondansetron HCl oral solution
- ondansetron HCl oral tablet
- ondansetron oral tablet,disintegrating
- paricalcitol oral capsule
- penicillin G potassium injection recon soln 20 million unit
- penicillin G sodium injection recon soln
- Pentam injection recon soln
- Perforomist inhalation solution for nebulization

- piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram
- Plasma-Lyte 148 intravenous parenteral solution
- Plasma-Lyte A intravenous parenteral solution
- Plenamine intravenous parenteral solution
- potassium chlorid-D5-0.45%NaCl intravenous parenteral solution
- potassium chloride in 0.9%NaCl intravenous parenteral solution 20 mEq/L, 40 mEq/L
- potassium chloride in 5 % dex intravenous parenteral solution 20 mEq/L, 40 mEq/L
- potassium chloride in LR-D5 intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.2%NaCl intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.3%NaCl intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.9%NaCl intravenous parenteral solution
- Premasol 10 % intravenous parenteral solution
- Premasol 6 % intravenous parenteral solution
- Procalamine 3% intravenous parenteral solution
- Prograf oral granules in packet
- Prosol 20 % intravenous parenteral solution
- Pulmozyme inhalation solution
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- rifampin intravenous recon soln
- Sandimmune oral solution
- sirolimus oral solution
- sirolimus oral tablet
- Somatuline Depot subcutaneous syringe
- Somavert subcutaneous recon soln
- Synribo subcutaneous recon soln
- tacrolimus oral capsule
- TDVAX intramuscular suspension
- Teflaro intravenous recon soln
- testosterone cypionate intramuscular oil 100 mg/mL, 200 mg/mL (1 ML)
- testosterone enanthate intramuscular oil
- tobramycin in 0.225 % NaCl inhalation solution for nebulization
- tobramycin sulfate injection solution
- Travasol 10 % intravenous parenteral solution
- Trelstar intramuscular suspension for reconstitution
- TrophAmine 10 % intravenous parenteral solution
- Trophamine 6% intravenous parenteral solution
- Twinrix (PF) intramuscular syringe
- vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg
- Varubi oral tablet
- voriconazole intravenous recon soln
- Xgeva subcutaneous solution
- Zortress oral tablet

Details

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

ConnectiCare

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ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. ConnectiCare Insurance Company, Inc. is an HMO SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in ConnectiCare depends on contract renewal.
Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Beneficiaries must use network pharmacies to access their premium and/or copayment/coinsurance may change on January 1, 2021.

This document includes ConnectiCare Medicare Plan's partial formulary as of October 6, 2019. For a complete, updated formulary, please visit our website at www.connecticare.com/Medicare or call the Member Services number below.

For alternative formats or language, please call Member Services toll free at:

1-800-CCI-CARE (1-800-224-2273) between the hours of 8:00 a.m. and 8:00 p.m., seven days a week.

TTY/TDD users should call 711.

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