Prior authorization and step therapy coverage

The plan covers hundreds of different medications, including some that require prior authorization and step therapy.

Talk to your doctor to find the right drug therapies that your prescription plan covers.

This list is current as of October 12, 2018. It is subject to change without notice. If you have a question about any drug, call MESSA Member Services at 800.336.0013.

Prior authorization

To ensure compliance with FDA-approved safe prescribing guidelines, certain drugs require prior authorization before MESSA will cover them. Your doctor must submit documentation to support the need for the prescription.

If prior authorization is not obtained for a drug that requires one, MESSA will not cover the medication.

Step therapy

Drugs subject to step therapy require previous treatment with one or more preferred drugs before coverage is approved.

If your prescribed drug does not meet the step therapy criteria, it may not be covered.

Drug Name	Prior Authorization Requirements
Absorica®	Coverage requires trial of generic isotretinoin.
Abstral®	Coverage requires all of the following be met: 1. Documentation supporting that medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose narcotics 3. Currently receiving a long acting narcotic 4. Treatment failure or intolerance to oral immediate release narcotics (morphine IR, oxycodone IR, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq
Aciphex® sprinkle	Requires failure of or intolerance to all generic alternatives: generic omeprazole (Prilosec) and generic pantoprazole (Protonix) and generic lansoprazole (Prevacid/Prevacid Solutab) and generic rabeprazole (Aciphex).
Actemra® SC	Coverage requires documentation of the following: 1. Age ≥ 18 years' old 2. Diagnosis of Rheumatoid Arthritis 3. Three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD) Examples of DMARDS include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold, penicillamine. Or 1. Diagnosis of Giant Cell Arteritis (GCA)

Adcirca®	Coverage requires documentation to support the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1). 2. Treatment failure or intolerance to generic Revatio.
Addyi™	Coverage requires documentation to support the following: 1. Premenopausal female ≥ 18 years old. 2. Diagnosis of acquired, generalized Hypoactive Sexual Desire Disorder (HSDD) with documentation that condition is causing clinically significant distress and has been ongoing for more than 6 months. 3. Other causes (such as relationship difficulty, substance abuse, medication side effects) of HSDD must be ruled out.
Adempas®	Coverage requires documentation to support the following: 1. Diagnosis of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO GROUP 4) after surgical treatment or inoperable CTEPH. 2. Diagnosis of Pulmonary Arterial Hypertension (PAH)(WHO Group 1)
Adlyxin®	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or Bydureon Bcise, Byetta, Trulicity and Victoza
Adzenys ER™	Coverage requires documentation to support the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder. 2. Age ≥ 6 years old. 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation. 4. Or physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD(g), Adderall XR(g))
Adzenys XR-ODT™	Coverage requires all of the following be met: 1. Diagnosis of Attention Deficit Hyperactivity Disorder. 2. Age ≥ 6 years old. 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation. 4. Or physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD(g), Adderall XR(g))
Afrezza®	Coverage is provided when the member has experienced treatment failure or intolerance to Novolog
Aimovig™	Coverage requires documentation to support the following: 1. Age ≥ 18 years' old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines

Akynzeo®	Coverage will be provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril). 2. Preferred NK1 antagonist (ex. Emend). 3. Glucocorticoid (dexamethasone) Initial approval 1 year Renewal requires documentation of continuation of chemotherapy
Alecensa®	Coverage requires documentation to support the following: Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity
almotriptan (Axert®)	Requires trial of 2 generic triptans: (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT)
alogliptin (Nesina®)	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
alogliptin - metformin (Kazano®)	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
alogliptin – pioglitazone (Oseni®)	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
Alunbrig™	Coverage requires documentation of the following: Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib (Xalkori)
Ampyra®	Coverage may be provided in patients ≥ 18 years of age when the criteria below are met: 1. Diagnosis of multiple sclerosis. 2. Prescribing physician is a neurologist. 3. Patient has documented difficulty walking, resulting in significant limitations of instrumental activities of daily living. 4. Clinical notes are provided documenting two measurements with variability within 10% demonstrating the patient is able to walk 25 feet. The faster time of the two measurements will serve as the baseline value. Ambulatory function assessed with the timed 25-foot walk (T25FW). 5. Patient does not have a history of seizure. 6. Patient does not have moderate to severe renal impairment (CrCl ≤ 50 ml/min). 7. Patient does not have prior treatment and failure with Ampyra.

	Initial approval length is for 6 months. Coverage may be renewed for 12 months when the following criteria are met: 1. Clinical notes are provided documenting improvement in walking speed by at least 20% as assessed by the timed 25-foot walk. 2. Indication that the significant limitations of instrumental activities of daily living have improved/resolved as a result of increased speed of ambulation. Coverage may be renewed annually thereafter (12 month intervals) when clinical notes document no deterioration in walking speed, compared to the previous walking speed measured for renewal of therapy, as assessed by the timed 25-foot walk.
Amrix®	Coverage requires previous trial and failure of generic immediate-release cyclobenzaprine (Flexeril).
Anadrol-50®	Approved for the treatment of clinically diagnosed anemia (documentation must support the trial of standard supportive measures for treating anemia including: transfusion, correction of iron, folic acid, vitamin B12, or pyridoxine deficiency, antibacterial therapy and the appropriate use of corticosteroids) or for the treatment of HIV-associated wasting or if prophylactic therapy is needed in patients with hereditary angioedema.
anastrozole (Arimidex®)	Coverage review required for males only. Approved only for ER-positive breast cancer treatment.
Aplenzin®	Requires trial/failure of at least three generic or preferred antidepressant agents, one of which must be generic bupropion (Wellbutrin, Wellbutrin XL).
Aptiom®	Coverage requires documentation to support the following: 1. Treatment of seizures in patients with epilepsy 2. Has experienced treatment failure or intolerance to at least 3 generic alternatives for the treatment seizures Or Currently stable on Aptiom for the treatment of seizures
Aranesp®	Coverage requires all of the following be met: 1. FDA approved indication 2. Hemoglobin less than 10 g/dl 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.
Arcalyst®	Only FDA-approved for treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years and older.
Austedo™	Coverage requires documentation to support the following: 1. Diagnosis of chorea associated with Huntington's disease Or 2. Diagnosis of Tardive Dyskinesia

Beconase® AQ	Requires trial and failure/intolerance of 2 of the following intranasal steroids: generic fluticasone (Flonase), generic flunisolide (Nasarel) or generic triamcinolone (Nasacort AQ).
Belbuca™	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.
Belsomra®	Requires treatment failure of 3 out of 4 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), or trazodone (Desyrel)
Belviq® / Belviq XR®	Coverage requires documentation of the following: 1. 18 years and older 2. Documentation of BMI ≥ 30, or ≥ 27 with one weight related co morbid condition. 3. Current weight (within 30 days) must be submitted to the plan for review. 4. Documentation of concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Continued coverage (up to 12 months) may be authorized for members who provide documentation of weight loss of at least 5% during the first 12 weeks of treatment. Continued coverage of Belviq may be provided if the member has maintained at least a 5% weight loss from baseline.
Benlysta™	Coverage requires documentation to support the following: 1. ≥18 years old 2. Diagnosis of systemic lupus erythematosus (SLE) 3. Trial and treatment failure or intolerance of two or more of the following: hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide or mycophenolate. 4. Does not have severe active lupus nephritis or severe active CNS lupus Not to be used in combination with other biologics, B-cell targeted therapies or IV cyclophosphamide
Bethkis®	Coverage is provided when the following criteria are met: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa. 2. Trial of generic tobramycin inhalation nebulization solution

bexarotene (Targretin®)	Coverage requires documentation to support the following: 1. Diagnosis of cutaneous T-cell lymphoma (CTCL) 2. Treatment failure or intolerance to at least one systemic therapy Initial approval: 1 year Renewal: No evidence of disease progression
Binosto™	Coverage requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate)
Bonjesta	Coverage requires documentation to support the following: 1. Treatment of nausea and vomiting of pregnancy 2. Trial and treatment failure of the individual agents (doxylamine and pyridoxine) in combination. Approval length: 9 months
Bosulif®	Coverage requires documentation to support the following: Diagnosis of chronic phase Philadelphia chromosome-positive (PH+) chronic myelogenous leukemia (CML) Or Diagnosis of chronic, accelerated, or blast phase PH+ CML with resistance or intolerance to prior therapy Initial approval: 1 year Renewal: Evidence of tumor response, no evidence of disease progression.
Braftovi™	Coverage requires documentation of the following: FDA approved indications
Briviact® oral suspension + tablet	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives, one of which must be generic Keppra Or 1. Currently stable on Briviact for the treatment of seizures
buprenorphine (Subutex®)	Coverage will be provided for members who are pregnant or breastfeeding and are being treated for opioid dependence.
Bystolic®	Coverage requires documentation to support the following: Trial and treatment failure to at least two preferred cardioselective betablockers such as atenolol (Tenormin), metoprolol (Toprol/XL), bisoprolol (Zebeta), betaxolol (Kerlone)

Cabometyx™	Coverage requires documentation of the following: 1. Diagnosis of advanced renal cell carcinoma 2. Prescribed by an oncologist. 3. Age ≥ 18 years old. Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity
Calcipotriene and Betamethasone ointment (Taclonex®)	Coverage requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid (ex. generic Diprolene ointment, generic Psorcon, or generic Temovate) And 2. Using in combination with generic Dovonex
Calquence®	Coverage requires documentation to support treatment of FDA approved indications.
Cambia	Coverage requires all of the following are met" 1. Treatment of acute migraine attacks. 2. Trail and failure to oral diclofenac and two other generic oral non-steroidal anti-inflammatory drugs (NSAID).
Caprelsa®	Coverage is provided for the treatment of the FDA approved indications.
Carbaglu®	Covered for the treatment of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS).
Caverject®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Cayston®	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in members with cystic fibrosis.
Cerdelga™	Treatment of adult patients with Gaucher disease type 1 who are cytochrome P450 (CYP-450) 2D6 extensive metabolizers, intermediate metabolizers or poor metabolizers. Renewal Criteria: Provide documentation of stability or improvement in disease (this may include, but is not limited to, hematologic indices, and/or MRI of spine/femurs)
Chantix®	Requires trial and failure of 2 preferred agents such as generic bupropion extended release (Zyban), nicotine patch, nicotine gum, nicotine lozenge for $0 copayment.
Chenodal™	Coverage requires documentation to support the following: 1. Treatment of gallstones 2. Ineligible for surgery 3. Treatment failure or intolerance to Actigall (ursodiol) Coverage is limited to 24 months

Cholbam™	Coverage will be provided for: 1. Treatment of bile acid synthesis disorder due to single enzyme defects (SEDs) Or 2. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption. 3. Prescriber is a hepatologist or a pediatric gastroenterologist. 4. Requires submission of baseline AST, ALT, GGT, alkaline phosphate, bilirubin and INR. Renewal requires documentation of: 1. Improvement of liver function from baseline tests. 2. Lack of complete biliary obstruction. 3. Body weight increase by 10% from baseline or stable at greater than the 50th percentile
chorionic gonadotropin (HCG) (Novarel)	Coverage of the requested drug is provided when all the following are met: 1. The treatment is being provided by a board -certified infertility specialist. 2. It is being prescribed in accordance with generally accepted medical practice. 3. The members benefit provides for coverage for infertility medications. Or For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males. Or 2. Prepubertal cryptorchidism not caused by anatomic obstruction. Coverage is provided in accordance with your medical fertility benefit
Cialis®	Cialis for daily dosing requires: Diagnosis of Benign Prostatic Hyperplasia (BPH) and trial and failure or intolerance of an alpha-blocker and a 5-alpha reductase inhibitor. May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.

Cimzia®	Coverage requires documentation to support the following: 1. Age 18 or older and for the treatment of acute exacerbation of moderate to severe Crohn's disease when the following criteria are met (a and b): a. Treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated or patient has been unable to taper, or patient is experiencing breakthrough disease while stabilized on an immunomodulatory medication for at least 2 months. b. Previous trial/failure/contraindication of Humira. Or 2. Age 18 or older and for the treatment of rheumatoid arthritis when the following criteria are met (a and b): a. Treatment failure with a three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine). b. Treatment failure or documented intolerance to 2 or more: Humira, Enbrel, Actemra subcutaneous or, Xeljanz/Xeljanz XR. Or 3. Age 18 or older and for the treatment of ankylosing spondylitis when the following criteria is met: a. Treatment failure or documented intolerance to 2 or more: Humira, Enbrel, or Cosentyx. Or 4. Age 18 or older and for the treatment of psoriatic arthritis when the following criteria are met (a and b): a. Treatment failure with a three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine). b. Treatment failure or documented intolerance to 2 or more: Humira, Enbrel, Stelara, or Cosentyx. 5. Diagnosis of psoriasis a. Trial and treatment failure of phototherapy b. Trial and treatment failure of a generic oral systemic agent (cyclosporine, methotrexate, acitretin) c. Trial and treatment failure to two of the following: Cosentyx, Humira, Otezla or Stelara
Cometriq™	Coverage will be provided for the treatment of patients with progressive, metastatic medullary thyroid cancer. Therapy is considered investigational for all other conditions. Authorization will be reviewed annually to confirm that current criteria are met, and that the medication is effective and to assess for disease progression and intolerance.
Compounds	Coverage criteria include all the below: 1. The compound is medically necessary for the member's condition. 2. The compound contains only FDA-approved drugs. 3. There are no appropriate FDA-approved commercial formulations of the compound available. 4. There is medical literature to support the safety, effectiveness and route of administration of the compound.

Contrave®	Coverage requires documentation of the following: 1. 18 years and older 2. Documentation of BMI ≥ 30, or ≥ 27 with one weight related co morbid condition. 3. Current weight (within 30 days) must be submitted to the plan for review. 4. Documentation of concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Continued coverage (up to 12 months) may be authorized for members who provide documentation of weight loss of at least 5% during the first 16 weeks of treatment. Continued coverage of Contrave may be provided if the member has maintained at least a 5% weight loss from baseline.
Corlanor®	Coverage requires all of the following be met: 1. Diagnosis of class NYHA II to IV heart failure, with left ventricular ejection fraction ≤ 35%. 2. Member is in sinus rhythm with resting heart rate ≥ 70 beats per member. 3. The drug is being prescribed by or in consultation with a cardiologist. 4. Stable on maximally tolerated dose of one of the following beta blockers: metoprolol succinate, carvedilol or bisoprolol. 5. Must not be used in combination with Entresto.
Cosentyx™	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Patient is 18 years of age or older 3. Treatment with phototherapy or photochemotherapy was ineffective, contraindicated, or not tolerated 4. Treatment with at least one oral systemic agent for plaque psoriasis was ineffective or not tolerated, unless contraindicated. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin. Or 1. Diagnosis of psoriatic arthritis 2. Patient is 18 years of age or older 3. Treatment with at least one generic oral systemic agent. (Examples: cyclosporine, methotrexate and lefludomide) Or Age 18 years or older and diagnosis of ankylosing spondylitis
Cotellic™	Coverage requires documentation of the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation 2. Using in combination with Zelboraf 3. Prescribed by an oncologist
Cuvitru™	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Continued coverage may be authorized by providing documentation of improvement.
Cycloset®	Coverage is provided in members who have experienced treatment failure or intolerance to at least 2 generic oral diabetes drugs.
Cystaran™	Coverage will be provided for the treatment of corneal cystine crystal accumulation in patients with cystinosis, when taking in combination with oral Cystagon.

Daklinza™	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Prescribed in conjunction with Sovaldi for the treatment of chronic hepatitis C genotype 1 or 3 3. Provide a recent fibrosis score (measure of liver damage) 4. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 5. Documentation of previous treatment experience for Hepatitis C 6. Counseling on avoidance of alcohol 7. Patient and physician must attest to compliance while taking the treatment regimen 8. Trial of preferred medication: Epclusa or Zepatier Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier.
Daliresp®	Coverage requires the following be met: 1. Diagnosis of chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations. 2. Trial of long-acting beta agonist (LABA) 3. Trial of an anticholinergic medication 4. Trial of an inhaled corticosteroid
Daraprim®	Coverage is provided for malaria chemoprophylaxis and the treatment of malaria or toxoplasmosis.
Desvenlafaxine ER®	Requires trial and failure of at least three generic or preferred antidepressant agents
Dexilant™	Requires failure of or intolerance to all generic alternatives: generic omeprazole (Prilosec) and generic pantoprazole (Protonix) and generic lansoprazole (Prevacid/Prevacid Solutab) and generic rabeprazole (Aciphex).
Diclegis®	Coverage requires documentation to support the following: 1. Treatment of nausea and vomiting of pregnancy 2. Trial and treatment failure of the individual agents (doxylamine and pyridoxine) in combination. Approval length: 9 months
diclofenac sodium 3% gel (Solaraze®)	Coverage requires documentation to support the following: 1. Diagnosis of actinic keratosis 2. Trial and treatment failure of 3 different treatment courses using cryotherapy or phototherapy 3. Trial of 2 topical generic or preferred agents which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara) Approve for 3 months Renewal criteria: Documentation of recurrence and/or new lesions
Doptelet®	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Diagnosis of thrombocytopenia in chronic liver disease 3. Platelet count < 50,000 mcL 4. Scheduled to undergo a procedure Approval: 1 month

Doryx® / Doryx® MPC	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).
Doxepin topical cream	Coverage requires documentation to support the following: 1. Diagnosis of atopic pruritic or lichen simplex chronicus 2. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 3. Trial and treatment failure to one preferred topical calineurin inhibitor (tacrolimus, pimecrolimus Or 1. Diagnosis of peripheral neuropathic pain 2. Trial and treatment failure of two over-the-counter topical analgesics 3. Trial and treatment failure of one preferred topical non-steroidal anti-inflammatory drug (NSAID) Approve for 1 month
doxycycline hyclate (Doryx®)	Requires documentation that the member had a trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).
doxycycline lr dr (Oracea®)	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).
doxycycline monohydrate (Adoxa®/Adoxa® Pak)	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).
Duopa™	Coverage requires documentation to support the following: 1. Diagnosis of advanced Parkinson's disease 2. Member has a feeding tube
Dupixent®	Coverage requires documentation of the following: 1. Age ≥ 18 years' old 2. Prescribed by a dermatologist or allergist 3. Treatment of moderate to severe atopic dermatitis 4. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 5. Trial and treatment failure with one preferred topical calcineurin inhibitor (generic Protopic, Elidel) 6. Trial and treatment failure or contraindication to photochemotherapy (PUVA) 7. Trial and treatment failure or contraindication to one preferred oral systemic agent for atopic dermatitis. (Ex. cyclosporine, methotrexate, azathioprine and mycophenolate mofetil).
Duzallo®	Coverage requires documentation to support the following: 1. Diagnosis of hyperuricemia associated with gout 2. Trial and failure of allopurinol 3. Serum uric acid level > 6

Dyanavel™ XR	Coverage requires all of the following be met: 1. Diagnosis of Attention Deficit Hyperactivity Disorder. 2. Age ≥ 6 years old. 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation. 4. Or physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD(g), Adderall XR(g)).
Dymista®	Requires documentation that the member has experienced treatment failure of or intolerance to 2 generic intranasal steroid products one of which must be intranasal generic fluticasone (Flonase) used in combination with intranasal generic azelastine (Astelin) for a 3-month trial.
Ecoza™	Coverage requires documentation of the following: 1. Age ≥ 12 years' old 2. Diagnosis of tinea pedis 3. Treatment failure of 2 topical over-the-counter antifungal agents 4. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)
Edarbi™	Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB)
Edarbyclor™	Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB)
Edex®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Edluar®	Requires treatment failure of 3 out of 4 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), or trazodone (Desyrel).
Egrifta®	Coverage will be provided for the FDA approved indication only. The reduction of excess abdominal fat in HIV-infected patients with lipodystrophy and supporting documentation will be required for the following criteria: 1. Patient is infected with human immunodeficiency virus (HIV). 2. Patient is receiving antiretroviral therapy (ART). 3. Weight loss efforts (dietary modification and exercise) have been ineffective in reducing the excess abdominal fat due to lipodystrophy. 4. Documentation of the medical complication(s) caused by excess abdominal fat. 5. The medical complication(s) due to excess abdominal fat are unresponsive to conventional therapy. Initial approval is for 6 months. Coverage may be renewed for 12 months when the following criteria are met: 1. Clinical documentation indicating a decrease in waist circumference (decrease in lipodystrophy). 2. Reduction of complication(s) provided in the initial request caused by excess abdominal fat. Coverage is not provided for weight loss management in patients with HIV infection.

Eletriptan (Relpax®)	Coverage requires documentation to support the following: Trial of 2 generic triptans (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).
Embeda®	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.
Emflaza™	Coverage requires all of the following: 1. Diagnosis of Duchenne Muscular Dystrophy (DMD) 2. Prescribed by or in consultation with a physician who specializes in the treatment of DMD 3. Age ≥ 5 years' old 4. Trial and treatment failure of prednisone or prednisolone.
Enbrel®	Coverage requires documentation of the following: 1. Rheumatoid arthritis, juvenile RA or psoriatic arthritis: Requires three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine). 2. Ankylosing spondylitis: Requires therapy is being supervised by a Rheumatologist. 3. Moderate to severe psoriasis: a. Trial and treatment failure with topical corticosteroids b. Trial and treatment failure with phototherapy or photochemotherapy (unless contraindicated. c. Trial and treatment failure with Humira d. Prescriber is a dermatologist
Endari™	Coverage requires documentation of the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 5 years' old 3. Trial and treatment failure of hydroxyurea
Enstilar®	Coverage requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid (ex. generic Diprolene ointment, generic Psorcon, generic Temovate) in combination with generic Dovonex. 2. Trial and treatment failure with generic Taclonex ointment (requires prior authorization

Epclusa®	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. Provide a recent fibrosis score (measure of liver damage) 4. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 5. Documentation of previous treatment experience for Hepatitis C 6. Counseling on avoidance of alcohol 7. Patient and physician must attest to compliance while taking the treatment regimen Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.
Epiduo® Forte	Coverage requires all of the following: 1. Trial of generic Benzaclin or generic Benzamycin 2. Trial of combination of individual agents' benzoyl peroxide 2.5% and adapalene 0.3%
Epogen®	Coverage requires all of the following be met: 1. FDA approved indication 2. Hemoblogin less than 10 g/dl 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.
Erleada™	Coverage requires documentation to support treatment of FDA approved indications.
Erivedge™	Coverage will be provided for the following: 1. Prescriber is an oncologist or dermatologist. 2. Diagnosis of metastatic Basal Cell Carcinoma (mBCC). Or 1. Diagnosis of locally advanced Basal Cell Carcinoma (laBCC). 2. Recurrence following surgery or not a candidate for surgery or radiation therapy Initial coverage approval: 6 months. Continued coverage will be reviewed annually to assess disease progression and intolerance.
Esbriet®	Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF).
Eucrisa™	Coverage requires documentation to support the following: 1. Age ≥ 2 years old 2. Diagnosis of atopic dermatitis 3. Trial and treatment failure to two topical steroids, one of which must be a medium or high potency product 4. Trial and treatment failure to one preferred topical calcineurin inhibitor (generic Protopic, Elidel)

Evekeo™	Coverage will be provided when one of the following have been met. (A, B or C): A. Narcolepsy: 1. ≥ 6 years of age, 2. Trial of generic Adderall IR and a generic methylphenidate. B. ADHD: (Attention hyperactivity deficit disorder) 1. 3-6 years of age. i. Trial of generic amphetamine or 2. ≥6rs old, i. Trial of generic amphetamine and generic methylphenidate product. C. Obesity: 1. ≥ 12 years of age, 2. Documentation of BMI > 30 kg/m2, 3. Documentation of lifestyle modifications, and 4. Documentation of previous failed weight loss therapies.
exemestane (Aromasin®)	Coverage review required for males only. Approved only for ER-positive breast cancer treatment.
Exjade®	Coverage will be provided if the following criteria has been met: Chronic iron overload due to transfusions: 1. ≥ 2 years of age. 2. Trial and failure of Desferal. 3. Baseline ferritin level must be submitted. Or Chronic iron overload in nontransfusion-dependent thalassemia syndromes: 1. ≥ 10 years of age 2. Trial and failure of Desferal. 3. Baseline Ferritin level must be submitted.
Fabior™	Coverage requires documentation to support the following: Trial and treatment failure to both generic adapalene (Differin) and generic tretinoin (Retin-A, Avita).
Fanapt®	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone)
Farydak®	Coverage requires all of the following: 1. Diagnosis of multiple myeloma 2. Prescriber is an oncologist. 3. Member has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (ex. Revlimid, Thalomid). 4. Will be used in combination with bortezomib and dexamethasone.
fenoprofen calcium (Nalfon®,Fenortho™, Profeno®)	Coverage requires documentation to support the following: 1. Age ≥18 years old 2. Treatment of mild to moderate pain
fentanyl citrate buccal lollipop (Actiq®)	Coverage requires all of the following be met: 1. Documentation supporting that medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose narcotics 3. Currently receiving a long acting narcotic 4. Treatment failure or intolerance to oral immediate release narcotics (morphine IR, oxycodone IR, or hydrocodone containing products)

Fentora®	Coverage requires all of the following be met: 1. Documentation supporting that medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose narcotics 3. Currently receiving a long acting narcotic 4. Treatment failure or intolerance to oral immediate release narcotics (morphine IR, oxycodone IR, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq
Ferriprox® oral solution + tablet	Coverage requires the following be met: 1. Diagnosis of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate. 2. Documentation of treatment failure or intolerance to Desferal and Exjade. 3. Baseline absolute neutrophil count (ANC) must be submitted. 4. Baseline serum ferritin level must be submitted. Renewal requires documentation of > 20% decline in serum ferritin level from baseline
Fetzima™	Requires trial/failure of at least three generic or preferred antidepressant agents.
Finacea® foam	Coverage will be provided when all of the following have been met: Trial of all of the following: 1. Generic topical metronidazole 2. Generic topical sulfacetamide 10%-sulfur 5% 3. Generic oral tetracycline, generic doxycycline or generic minocycline
Firazyr®	Coverage requires documentation to support the following: Diagnosis of type 1 or type 2 hereditary angioedema (HAE) as confirmed by genetic testing or with all the following laboratory findings: 1. Normal C1q levels 2. C4 levels below the limits of the laboratory's normal reference 3. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range
Flector®	Coverage requires documentation to support the following: 1. Diagnosis of acute pain due to minor strains, sprains or contusions. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs.
fluorouracil (Carac®)	Coverage requires all of the following be met: 1. Diagnosis of actinic keratosis. 2. Member has not responded to or has been intolerant of 3 different treatment courses using cryotherapy or phototherapy 3. Trial of Tolak 4% cream Initial approval: 1 month Renewal criteria: Documentation of recurrence and or new lesions. Renewal approval: 1 month

Follistim® AQ	Coverage of the requested drug is provided when all the following are met: 1. The treatment is being provided by a board -certified infertility specialist. 2. It is being prescribed in accordance with generally accepted medical practice. 3. Requires a previous trial of Gonal-f or Gonal-f RFF. 4. The members benefit provides for coverage for infertility medications. Coverage is provided in accordance with your medical fertility benefit
Forfivo XL®	Requires trial/failure of at least three generic or preferred antidepressant agents, one of which must be generic bupropion (Wellbutrin, Wellbutrin XL).
Forteo®	Coverage requires documentation to support the following: 1. Treatment of osteoporosis 2. Trial and failure or contraindication to an oral generic bisphosphonate (generic Fosamax, generic Boniva, generic Actonel) Forteo will be approved for a maximum of two years.
Fosamax Plus D®	Coverage requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate)
frovatriptan (Frova®)	Coverage requires documentation to support the following: Trial of 2 generic triptans (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).
Gammagard™ Gammaked™ Gamunex-C®	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Continued coverage may be authorized by providing documentation of improvement.
Gattex®	Coverage requires documentation to support the following: 1. 18 years of age or older 2. Diagnosis of Short Bowel Syndrome (SBS) 3. Dependent on parenteral support ≥ 12 months
Gelnique®	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies
Gilotrif™	Coverage requires documentation to support the following: 1. Prescribed by an oncologist 2. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test Or 3. Diagnosis of metastatic squamous NSCLC that has progressed following platinum-based chemotherapy. Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity

Glassia™	Coverage requires documentation of the following: 1. Age must be 18 years or older 2. Must be a nonsmoker 3. Member must have serum levels of alpha-1 antitrypsin (AAT) that are less than 80 mg/dl consistent with phenotypes PiZZ, PiZ (null), or Pi (null, null) of AAT a. Phenotype/genotype testing may be requested for additional support of alpha-1 antitrypsin deficiency 4. Member must have symptoms with their emphysema 5. Member must have failing lung function, as demonstrated by a decrease in the FEV1 (35-60% of predictive value) laboratory test Renewal Criteria: Documentation of evidence of efficacy improvement (i.e. elevation of AAT levels above threshold of 80 mg/dl)
Glyxambi®	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial and treatment failure of Qtern (dapagliflozin/saxagliptin)
Gonal-f® / Gonal-f® RFF	Coverage of the requested drug is provided when all the following are met: 1. The treatment is being provided by a board -certified infertility specialist. 2. It is being prescribed in accordance with generally accepted medical practice. 3. The members benefit provides for coverage for infertility medications. Coverage is provided in accordance with your medical fertility benefit
Gralise®	Coverage requires documentation to support the following: 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≤ 65 years of age 3. Trial of generic Neurontin (gabapentin) 4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) Or 1. ≥ 65 years of age 2. Diagnosis of post-herpetic neuralgia (PHN) 3. Trial of generic Neurontin (gabapentin)
Grastek®	Coverage will be provided when all of the following have been met: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist.

Growth Hormone (adults) Genotropin® Norditropin® Nutropin® Nutropin® AQ Humatrope® Omnitrope® Saizen® Serostim® Zomacton® Zorbtive™	Coverage requires documentation to support the following: 1. Written by an endocrinologist, gastroenterologist, or infectious disease specialist. 2. Documentation of at least one known cause for pituitary disease or condition affecting pituitary function (i.e. pituitary tumor, traumatic brain injury, surgical damage, hypothalamic disease, irradiation, trauma or infiltrative disease) AND one of the following (A, B, C or D): A. • Failed at least one clinically validated, clearly documented growth hormone stimulation test ○ For suspected growth hormone deficiency due to traumatic brain injury the following must also be met: ▪ Adherence to screening recommendations for growth hormone deficiency as defined by the Glasgow Coma Scale (GCS) ▪ GH stimulation test must be administered at least one-year post brain injury ○ For history of childhood growth hormone deficiency, GH stimulation test to be done after growth hormone has been discontinued for at least one month • IGF-1 level below age and BMI-corrected lower limit of reference labs normal range B. • Failed at least one clearly documented, clinically validated growth hormone stimulation test • Documentation of two additional pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement • IGF -1 level below age and BMI-corrected lower limit of reference labs normal range C. • Documentation of three pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement • IGF-1 level below age and BMI-corrected lower limit of reference labs normal range D. • Failed at least two clinically validated, clearly documented GH stimulation tests • IGF-1 level below age and BMI corrected lower limit of reference labs normal range. Or • Diagnosis of AIDS wasting cachexia and both of the following: ○ Unexplained weight loss > 10% of baseline ○ Concomitant anti-viral therapy for the duration of treatment Or • Diagnosis of short bowel syndrome and ○ Receiving specialized nutritional support, which may include dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient supplements ○ Approval for 4 weeks of treatment Coverage for a non-preferred medication requires treatment failure to all preferred medications (Genotropin, Norditropin,and Nutropin AQ)
Growth Hormone (pediatrics) Genotropin® Norditropin® Nutropin® Nutropin® AQ Humatrope® Omnitrope® Saizen® Serostim® Zomacton® Zorbtive™	Coverage requires documentation to support the following: Written by pediatric endocrinologist, pediatric nephrologist, or trauma/burn surgeon. And 1.Diagnosis of growth hormone deficiency with: • Initial height measurements < 5th percentile for age and gender • Abnormal growth velocity for at least 6 months, • Initial subnormal growth hormone test, IGF-1 and IGFBP3 levels below normal age for children of the same age and gender. • Open epiphyses Or 2.Diagnosis of Turners Syndrome, Chronic Renal Insufficiency, SHOX deficiency, Noonan Syndrome, Prader-Willi Syndrome with: • Initial height measurements < 5th percentile for age and gender • Abnormal growth velocity for at least 6 months • Open epiphyses • Patient is not post-transplant (for CRI only)

	3.Small for Gestational Age (SGA) • Birth weight and/or length at least 2 standard deviations below the mean for gestational age • Fails to manifest catch-up growth by 2 years of age • Open epiphyses Or 1. Pediatric Burn 3. Burns over at least 40% of total body surface area Coverage for a non-preferred medication requires treatment failure to all preferred medications (Genotropin, Norditropin,and Nutropin AQ) Initial authorization period: Approved until 18th birthday
H.P. Acthar Gel®	Coverage will be provided for the treatment of infantile spasms for children less than 2 years old.
Haegarda®	Coverage requires documentation to support the following: 1. Diagnosis of type 1 or type 2 hereditary angioedema (HAE) as confirmed by genetic testing or with all the following laboratory findings: a. Normal C1q levels b. C4 levels below the limits of the laboratory's normal reference c. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range 2. Inadequate response or unable to use attenuated androgens (i.e. danazol, stanozol and oxandrolone)
Harvoni®	Coverage requires documentation to support the following: 1. Age 12 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. Provide a recent fibrosis score (measure of liver damage) 4. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 5. Documentation of previous treatment experience for Hepatitis C 6. Documentation if patient is eligible for 8 weeks of Harvoni 7. Counseling on avoidance of alcohol 8. Patient and physician must attest to compliance while taking the treatment regimen 9. Trial of preferred medication: Zepatier for genotypes 1, and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier.
Hetlioz™	Coverage requires documentation to support the following: 1. Diagnosis of Non-24-hour sleep-wake disorder 2. Trial and treatment failure or intolerance to over-the-counter melatonin 3. Trial and treatment failure to Rozerem 4. Age ≥ 18 years old
Hizentra®	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Continued coverage may be authorized by providing documentation of improvement.

Horizant®	Coverage requires documentation to support the following: 1. Diagnosis of Restless Leg Syndrome (RLS) 2. Trial and treatment failure of generic Mirapex (pramipexole) 3. Trial and treatment failure of generic Requip/XL (ropinirole) 4. Trial and treatment failure of generic Neurontin (gabapentin) Or 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≤ 65 years of age 3. Trial of generic Neurontin (gabapentin) 4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) Or 1. ≥ 65 years of age 2. Diagnosis of post-herpetic neuralgia (PHN) 3. Trial of generic Neurontin (gabapentin)
Humira®	Coverage requires documentation of the following: **1. Rheumatoid arthritis, juvenile idiopathic arthritis or psoriatic arthritis:** Requires three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine). **2. Ankylosing spondylitis** **3. Moderate to severe psoriasis:** Requires 3 months of previous treatment with topical corticosteroids and 3 months' treatment with phototherapy or photo chemotherapy (unless contraindicated) and therapy must be supervised by a Dermatologist. **4. Crohn's Disease:** Coverage for patients age 6 years and older with a diagnosis of moderately to severely active Crohn's disease with a history of inadequate response to conventional therapy. **5. Ulcerative Colitis:** Coverage for patients age 18 years and older with a diagnosis of moderately to severely active Ulcerative Colitis with a history of inadequate response to conventional therapy **6. Hiradenitis suppurativa:** Coverage for patients 18 years and older, prescribed by or in consultation with a dermatologist and requires a 3-month trial of oral antibiotics **7. Uveitis:** a. ≥ 18 years' old b. Diagnosis of non-infectious intermediate uveitis, posterior uveitis or panuveitis. c. Prescribed by ophthalmologist or rheumatologist d. Trial of an oral corticosteroid e. Trial of an oral immunomodulatory agent. Examples include: methotrexate, azathioprine, cyclosporine

HyQvia	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Continued coverage may be authorized by providing documentation of improvement.
Hysingla™ ER	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.
Ibrance®	Coverage requires documentation of the following: 1. Diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer (in combination with an aromatase inhibitor) Or 2. Diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer (in combination with fulvestrant) in women with disease progression following endocrine therapy.
Iclusig™	Coverage will be provided for: The treatment Philadelphia chromosome positive acute lymphoblastic (Ph+ALL) OR Philadelphia chromosome positive chronic myelogenous leukemia (Ph+CML) and documented T315I mutation or documented resistance or intolerance to preferred agents (i.e., imatinib etc). Authorization will be reviewed annually to confirm that current criteria are met and that the medication is effective (improvement in test results) and to assess for disease progression and intolerance.
Idhifa®	Coverage requires documentation of the following: Diagnosis of Acute Myeloid Leukemia
Imbruvica™	Coverage requires documentation to support treatment of FDA approved indications.
Increlex®	Approval will require all of the following (1, 2, 3, 4, 5 and 6): 1. Medication to be prescribed by a pediatric endocrinologist. 2. Diagnosis of one of the following: a. Severe primary IGF-1 deficiency or growth hormone gene deletion or b. genetic mutation of growth hormone receptor (Laron Syndrome) 3. Current height measurement at less than 3rd percentile for age and sex

	4. IGF-1 level greater than or equal to 3 standard deviations below normal 5. Normal or elevated growth hormone levels based on at least one growth hormone stimulation test 6. Open growth plates Authorizations shall be reviewed at least annually to confirm that current medical necessity criteria are met and that the medication is effective. Continued authorization in children may be given for up to 12 months until any one of the following conditions occurs: 1. Growth velocity is less than 2.5 cm/year. 2. Bone age in males exceeds 16 0/12 years of age. 3. Bone age in females exceeds 14 0/12 years of age.
Ingrezza™	Coverage requires documentation of the following: 1. Diagnosis of tardive dyskinesia 2. Age ≥ 18 years' old 3. Prescribed by psychiatrist or neurologist
Inlyta®	Coverage will be provided for patients with a documented diagnosis of Advanced Renal Cell Carcinoma (RCC) and documented trial of one prior systemic treatment.
Iressa®	Coverage requires documentation of the following: 1. Prescribed by an oncologist 2. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor (EGFR) exon 19 deletions or exon 21 (I858R) substitution mutations as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity
isotretinoin (13-cis-Retinoic Acid) (Amnesteem, Claravis, Myorisan, Zenatane)	Coverage requires documentation to support the following: 1. Treatment of severe acne 2. Age ≥ 12 years old 3. Trial and treatment failure to one oral antibiotic 4. Trial and treatment failure to three preferred topical therapies
Jadenu™ sprinkle & tablet	Coverage will be provided if the following criteria has been met: Chronic iron overload due to transfusions: 1. ≥ 2 years of age. 2. Trial and failure of Desferal. 3. Baseline Ferritin level must be submitted. Or Chronic iron overload in nontransfusion-dependent thalassemia syndromes: 1. ≥ 10 years of age. 2. Trial and failure of Desferal. 3. Baseline Ferritin level must be submitted.

Jakafi®	Coverage requires chart notes documenting all of the following: 1. Diagnosis of intermediate or high risk myelofibrosis 2. Refractory or not a candidate to hydroxyurea 3. Prescribing physician is an oncologist/hematologist 4. Imaging tests documenting spleen enlargement and measurement 5. Bone marrow testing documenting fibrosis 6. Documentation of disease symptoms (for example: abdominal discomfort, pain under left rib, night sweats, itching, bone/ muscle pain, and early satiety) 7. CBC and platelet count prior to initiation of therapy 8. Requested dose appropriate for platelet count and renal or hepatic impairment Or Diagnosis of Polycythemia vera and all of the following: 1. ≥ 18 years' old 2. Trial of hydroxyurea 3. Prescribing physician is an oncologist or hematologist Initial approval: 6 months Renewal for Polycythemia vera requires documentation of a reduction in phlebotomy requirements (supported by a recent CBC) and a reduction in spleen volume compared to baseline. Renewal for Myelofibrosis requires documentation of a reduction in spleen volume or a reduction in palpable spleen length and improvement in symptoms compared to baseline.
Jentadueto®	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
Jentadueto XR®	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
Juxtapid™	Coverage requires documentation to support the following: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) 2. Receiving optimal adjunctive therapies including a low-fat diet and other lipid lowering treatments 3. Trial and treatment failure of Repatha
Jynarque™	Coverage requires chart notes to support the following: 1. Patient is > 18 years of age 2. Diagnosis of autosomal dominant polycystic kidney disease (ADPKD) 3. Prescribed by, or in consultation with, a nephrologist

Kalydeco™	Coverage requires documentation of the following: 1. Diagnosis of Cystic Fibrosis (CF) 2. Documentation of FDA approved gene mutation confirmed by genetic testing. Initial approval = 12 months. Authorization may be reviewed at least annually to assess treatment response
Karbinal™ ER	Coverage requires trial and treatment failure to generic carbinoxamine and two other generic antihistamines
Keveyis™	Coverage of the requested medication requires all of the following be met: 1. Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis and related variants as confirmed by a genetic test or positive family history 2. Trial and failure of lifestyle modifications such as diet (potassium intake alterations) and exercise modifications. 3. Trial and failure of acetazolamide. 4. Prescriber is a neurologist, endocrinologist or a geneticist.
Kevzara®	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis 2. Prescribing physician is a rheumatologist 3. Treatment with one DMARD (must be methotrexate unless not tolerated or contraindicated) 4. Treatment with two of the following agents: Enbrel, Humira, Actemra Xeljanz or Xeljanz XR
Khedezla® ER	Requires trial and failure of at least three generic or preferred antidepressant agents
Kineret®	Coverage requires documentation of the following: 1. Diagnosis of Rheumatoid Arthritis 2. ≥ 18 years of age 3. Trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine) 4. Trial and treatment failure with two of the following: Actemra SC, Enbrel, Humira, Xeljanz/XR Or Requires a diagnosis of Neonatal-onset multisystem inflammatory disease. Continued authorization shall be reviewed at least annually, and documentation indicating that there is disease stability or improvement must be provided.
Kisqali® / Kisqali® Femara® Co-pack	Coverage requires documentation to support the following: Treatment of FDA approved indications. Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity

Korlym™	Coverage requires documentation of all the following: 1. Member is ≥ 18 years of age 2. Prescriber is an endocrinologist 3. Diagnosis of hypercortisolism as a result of endogenous Cushing's Syndrome 4. Diagnosis of type II diabetes mellitus (DM) or glucose intolerance secondary to hypercortisolism. 5. Surgical treatment has been ineffective or not a candidate for surgery. 6. Treatment failure or intolerance to a steroidogenesis inhibitor (such as ketoconazole or mitotane), unless contraindicated. 7. Failure to achieve blood glucose control with maximally titrated therapy to manage hyperglycemia. Must include at least 3 months of treatment with insulin. 8. Documentation of baseline 2 – hour glucose tolerance test if diagnosis is glucose intolerance. 9. HbA1c is required if diagnosis is type II DM. Renewal Criteria**:** Renewal requires documentation of ≥ 1% reduction in HbA1c from baseline or ≥ 25% improvement in glucose tolerance.
Kuvan®	Coverage requires documentation to support the following: 1. Treatment of phenylketonuria (PKU) 2. Following a phenylalanine-restricted diet
Kynamro™	Coverage requires the following be met: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing or by both of the following a. Untreated LDL > 500mg/dl b. Family history in both parents supporting a diagnosis of familial hypercholesterolemia based on genetic testing and/or laboratory values. 2. Receiving optimal adjunctive therapies including a low-fat diet and other lipid lowering treatments. Authorization will be reviewed annually to confirm that current criteria are met and that the medication is effective.
Latuda®	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone)
Lazanda®	Coverage requires documentation of the following: 1. Documentation supporting that medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose narcotics 3. Currently receiving a long acting narcotic 4. Treatment failure or intolerance to oral immediate release narcotics (morphine IR, oxycodone IR, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq

Lenvima™	Coverage requires documentation of the following: 1. Prescriber is an oncologist 2. Diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC) 3. Progression of disease after treatment with standard therapy Or 1. Diagnosis of advanced renal cell carcinoma 2. Treatment failure to one prior anti-angiogenic therapy 3. Using in combination with everolimus Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.
Letairis®	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Letrozole (Femara®)	Coverage review required for males only. Approved only for ER-positive breast cancer treatment.
Levitra®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Livalo®	Treatment failure or intolerance to at least two generic statins one of which is generic atorvastatin (Lipitor) at a dose of at least 40mg daily.
Lokelma™	Coverage requires documentation to support the following: 1. Treatment of hyperkalemia 2. Trial and treatment failure of a thiazide or loop diurectic if appropriate 3. Trial and treatment failure of Veltassa
Lonsurf®	Coverage requires: 1. Diagnosis of metastatic colorectal cancer 2. Previous treatment with a. fluoropyrimidine-, oxaliplatin-and irinotecan-based chemotherapy b. anti-VEGF biological therapy c. if RAS wild-type, an anti-EGFR therapy 3. Prescribed by an oncologist
Luzu®	Coverage requires all of the following be met: 1. Age ≥ 18 years' old 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure of 2 topical over-the-counter antifungal agents 4. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)

Lynparza™	Coverage requires documentation to support the following: 1. Diagnosis of germline BRCA mutated (as detected by an approved test) advanced ovarian cancer in patients who have been treated with 3 or more prior lines of chemotherapy. Or 2. Maintenance treatment for recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer in patients who are in complete or partial response to platinum-based chemotherapy Or 3. Diagnosis of BRCA-mutated, HER2-negative metastatic breast cancer in patients who have been treated with chemotherapy. If hormone receptor-positive disease, should have received a prior endocrine therapy (or be considered inappropriate for endocrine therapy) Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity
Lyrica®	Coverage of Lyrica will be provided for: 1. Adjunctive treatment for patients with partial-onset seizures Or 2. Treatment of diabetic neuropathic pain, post-herpetic neuralgia or neuropathic pain associated with spinal cord injury. a. If patient ≥ 65 years of age: After a 30-day trial of gabapentin. b. If patient < 65 years of age: After a 30-day trial of gabapentin and a tricylic antidepressant, such as amitriptyline, desipramine or imipramine. Or 3. Fibromyalgia: Treatment failure or intolerance to gabapentin and 3 of the following: a. Tricyclic antidepressant b. Selective serotonin reuptake inhibitors (SSRI) c. Serotonin and norepinephrine reuptake inhibitors (SNRI) d. Cyclopenzaprine (Flexeril) e. Tramadol (Ultram)
Lyrica CR®	Coverage requires the following be met: 1. Diagnosis of diabetic neuropathic pain or post-herpetic neuralgia a. If patient ≥ 65 years of age: After a trial of gabapentin. b. If patient < 65 years of age: After a trial of gabapentin and a tricylic antidepressant, such as amitriptyline, desipramine or imipramine. 2. Trial and failure of immediate release Lyrica
Mavyret™	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 in patients without any liver damage or with liver damage and having no symptoms from the damage. 3. Trial of the preferred medication: Epclusa or Zepatier for patient who are treatment naïve 4. Patients with HCV genotype 1 who have previously been treated with regimens containing an NS5A (nonstructural protein 5A) inhibitor or an NS3/4A protease inhibitor, but not both Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure to Epclusa or Zepatier

Mekinist™	Coverage requires documentation of the following: Monotherapy or in combination with Tafinlar (dabrafenib) 1. Diagnosis of unresectable or metastatic melanoma 2. Presence of BRAF V600E or V600K mutation In combination with Tafinlar (dabrafenib) only 1. Presence of BRAF V600 E mutation 2. Diagnosis of either metastatic non-small cell lung cancer or diagnosis of advanced or metastatic anaplastic thyroid cancer (ATC)
Mektovi®	Coverage requires documentation of the following: FDA approved indications
Miglustat (Zavesca™)	Coverage is provided for members 18 years of age or older for the treatment of Type 1 Gaucher's disease for whom enzyme replacement therapy is not a therapeutic option (eg, because of allergy, hypersensitivity, or poor venous access). Continued coverage may be authorized for members by providing documentation of stability or improvement in disease
minocycline (Solodyn®)	Requires documentation that the member had a trial and treatment failure or intolerance to generic minocycline immediate release capsules (Minocin)
Mircera®	Coverage requires documentation to support the following: 1. Treatment of FDA approved indications 2. Hemoglobin < 10g/dl 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.
mometasone furoate (Nasonex®)	Requires trial and failure/intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase). 2. Generic flunisolide (Nasarel). 3. Nasacort (over-the-counter)
Movantik™	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza
Mulpleta®	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Diagnosis of thrombocytopenia in chronic liver disease 3. Platelet count < 50,000 mcL 4. Scheduled to undergo a procedure Approval: 1 month

Muse®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Myalept™	Requires documentation that medication is used for replacement therapy to treat the complications of leptin deficiency, in addition to diet, in patients with congenital or acquired generalized lipodystrophy.
Myrbetriq®	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies.
Mytesi™	Coverage will be provided for the symptomatic relief of noninfectious diarrhea in patients with HIV/AIDS and on antiretroviral therapy.
naftifine (Naftin®)	Coverage is provided when all of the following have been met: 1. 18 years of age or older 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure to two topical over-the-counter antifungal agents 4. Treatment failure to two oral generic antifungal agents
Namenda XR™	Coverage requires documentation to support the following: Trial of generic memantine immediate release (Namenda IR)
Namzaric™	Coverage requires documentation to support the following: Already stable on memantine (Namenda) and donepezil (Aricept)
Natesto™	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.
Natpara®	Coverage of the requested drug is provided when all of the following criteria have been met: 1. The prescribing physician is an endocrinologist 2. Using as an adjunct to calcium and Vitamin D to control hypocalcaemia in patients with hypoparathyroidism 3. Currently on calcium and Vitamin D and hypocalcaemia is not well controlled.
Nerlynx™	Coverage requires documentation to support the following: 1. Diagnosis of early stage HER2 positive breast cancer 2. Previous treatment with trastuzumab (Herceptin)-based therapy

Neupro®	Coverage requires documentation to support the following: 1. Diagnosis of Parkinson's disease 2. Treatment failure or intolerance to generic Mirapex (pramipexole) and generic Requip (ropinirole). Or 1. Diagnosis of Restless leg syndrome 2. Treatment failure or intolerance to generic Mirapex (pramipexole), generic Requip (ropinirole) and generic Neurontin (gabapentin).
Nexavar®	Coverage is provided for the treatment of the FDA approved indications.
Nexium® Suspension	Requires failure of or intolerance to all generic alternatives: generic omeprazole (Prilosec) and generic pantoprazole (Protonix) and generic lansoprazole (Prevacid/Prevacid Solutab) and generic rabeprazole (Aciphex).
Nicotrol®, Nicotrol® NS	Requires trial and failure of 2 preferred agents such as generic bupropion extended release (Zyban), nicotine patch, nicotine gum, nicotine lozenge for $0 copayment.
Ninlaro®	Coverage requires the following be met: 1. Diagnosis of multiple myeloma 2. Using in combination with lenalidomide and dexamethasone 3. Have received at least on prior therapy 4. Prescribed by an oncologist or hematologist
Nityr™	Coverage requires documentation of the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine
Noctiva™	Coverage requires the following be met: 1. Diagnosis of nocturnal polyuria 2. Age ≥ 50 years' old 3. Lifestyle changes have been tried (including limiting fluids such as water, alcohol and caffeine, elevation of legs 4. Treatment failure or intolerance to one generic medication for over active bladder (OAB) (examples tolterodine, oxybutynin) 5. Trial of generic oral desmopressin
Northera™	Coverage will be provided when all of the following are met: 1. Diagnosis of orthostatic hypotension. 2. The prescribing physician is a cardiologist, endocrinologist, neurologist or physiatrist. 3. Trial of midodrine and fludrocortisone.

Nucynta® ER	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to generic extended release tramadol (Ultram ER) AND two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Methadone d. Buprenorphine transdermal patch (Butrans). Or 1. Diagnosis of Diabetic Peripheral Neuropathy (DPN) And 2. If the member is equal to or greater than 65 years of age: Trial and failure of generic gabapentin (Neurontin) AND generic duloxetine (Cymbalta). Or 3. If the member is less than 65 years of age: Trial and failure of generic gabapentin (Neurontin) and generic duloxetine (Cymbalta) and a tricyclic antidepressant such as amitriptyline, desipramine, nortriptyline or imipramine. Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.
Nucynta® immediate-release tablets	Coverage requires documentation to support the following: 1. Treatment failure or intolerance to generic immediate-release tramadol or tramadol/acetaminophen 2. Treatment failure or intolerance to two preferred immediate release narcotics, such as generic Percocet, generic immediate release morphine. Authorization: 1 year Renewal requires recent documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective.
Nuedexta®	Coverage requires all of the following be met: 1. Diagnosis of pseudobulbar affect (PBA) 2. Documentation of an underlying neurological condition causing symptoms of PBA (ex. Multiple Sclerosis, amyotrophic lateral sclerosis, Parkinsons Disease, stroke, traumatic brain injury)
Nuplazid™	Coverage will be provided when all of the following have been met: 1. Diagnosis of Parkinson's disease psychosis 2. Prescribed by a neurologist or psychiatrist Initial authorization: 1 year Renewal requires documentation of clinically significant improvement in psychosis symptoms

Ocaliva™	Coverage requires the following be met: 1. Prescribed by or in consultation with gastroenterologist or hepatologist 2. Diagnosis of primary biliary cirrhosis (PBC) confirmed by 2 of the 3 following American Association for the Study of Liver Diseases criteria: a positive test for antimitochondrial antibodies, elevated serum levels of alkaline phosphatase (ALP), histologic evidence of PBC based on liver biopsy 3. Must be 18 years or older 4. Documented inadequate response to ursodeoxycholic acid (UDCA) after at least one year at a dose of 13-15mg/kg/day or inability to tolerate UDCA 5. Baseline ALP and bilirubin 6. Complete biliary obstruction has been ruled out 7. Other causes of liver disease have been ruled out 8. Treatment plan must also include UDCA unless unable to tolerate it Initial approval: 1 year Renewal requires documentation that member is responding to therapy Renewal authorization: 1 year
Odactra™	Coverage requires documentation to support the following: 1. Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by a positive skin test or in vitro testing for IgE antibodies to house dust mites 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist
Odomzo®	Coverage requires all of following have been met: 1. Diagnosis of locally advanced basal cell carcinoma 2. Recurrence following surgery or radiation therapy or not a candidate for surgery or radiation therapy 3. Treatment failure of the preferred agent, Erivedge 4. Prescribed by an oncologist or dermatologist Initial coverage approval: 1 year. Continued coverage will be reviewed annually to assess disease progression and intolerance.
Ofev®	Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF).
Olumiant®	Coverage requires documentation to support the following: 1. Diagnosis of Rheumatoid Arthritis 2. Trial and treatment failure of an oral DMARD 3. Trial and treatment failure of two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR

Olysio™	Coverage requires documentation of the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1 or 4 3. Provide a recent fibrosis score (measure of liver damage) 4. Must be used in COMBINATION with appropriate medications (peg-interferon, ribavirin, and Sovaldi) 5. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 6. Documentation of previous treatment experience for Hepatitis C 7. Counseling on avoidance of alcohol 8. Patient and physician must attest to compliance while taking the treatment regimen 9. Trial of preferred medication: Epclusa or Zepatier Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier
Omnaris®	Requires trial and failure/intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasarel) 3. Nasacort (over-the-counter)
Onexton™	Coverage requires trial of all of the following: 1. The individual agents in combination (topical clindamycin plus benzoyl peroxide) 2. Duac(g) 3. Benzaclin(g)
Onfi® oral suspension + tablet	For the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome.
Onzetra™ Xsail™	Coverage requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) nasal spray and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).
Opana ER®	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.

Opsumit®	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Oralair®	Coverage will be provided when all of the following criteria has been met: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in this product. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist.
Orencia® SC	Coverage requires documentation to support the following: 1. Age 18 years and older 2. Rheumatoid arthritis and when patient has tried a three-month trial of Disease Modifying Anti-Rheumatic Drug (DMARD) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine) and failed TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR 3. Psoriatic arthritis and when patient has tried a three-month trial of DMARD and failed TWO of the following: Cosentyx, Enbrel, Humira, or Stelara. Or 1. Two years or older 2. Juvenile idiopathic arthritis (JIA) and when patient has tried a three-month trial of DMARD 3. Trial and treatment failure of Enbrel and Humira
Orenitram™	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Orfadin®	Coverage requires documentation of the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine
Orilissa™	Coverage requires documentation to support the following: 1. Treatment of pain associated with endometriosis 2. Trial of an oral NSAID 3. Trial of two hormone related therapies 4. Age ≥ 18 years old. 150mg: Approval length: 2 years 200mg: Approval length 6 months
Orkambi™	Coverage requires documentation of the following: 1. Diagnosis of cystic fibrosis (CF) in patients with two copies of the F508del mutation confirmed by genetic test. 2. Age ≥ 6 years' old 3. Baseline FEV-1 must be submitted. 4. Prescribed by pulmonologist in a Cystic Fibrosis center Initial approval: 6 months Renewal requires documentation of improvement in Cystic Fibrosis symptoms.

Otezla®	Coverage requires documentation of the following: 1. For the diagnosis of psoriatic arthritis: a. ≥ 18 years of age. b. Trial of oral DMARD. c. Trial of one of the following: Cosentyx, Enbrel, Humira or Stelara. Or 2. For the diagnosis of psoriasis: a. ≥ 18 years of age. b. Trial of topical steroids. c. Trial of light therapy.
Otrexup™	Criteria for coverage require a diagnosis of rheumatoid arthritis, juvenile rheumatoid arthritis, or psoriasis and trial and failure of oral methotrexate and intramuscular methotrexate.
Ovidrel®	Coverage of the requested drug is provided when all the following are met: 1. The treatment is being provided by a board -certified infertility specialist. 2. It is being prescribed in accordance with generally accepted medical practice. 3. The members benefit provides for coverage for infertility medications. Coverage is provided in accordance with your medical fertility benefit
oxandrolone (Oxandrin®)	Approved when used as an adjunct therapy to promote weight gain in patients who have had extensive surgery, chronic infection, or severe trauma or for therapy to offset protein catabolism associated with prolonged use of corticosteroids or for bone pain associated with osteoporosis or if prophylactic therapy is needed in patients with hereditary angioedema.
oxiconazole (Oxistat®)	Coverage is provided when all of the following have been met: 1. 12 years of age or older 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure to two topical over-the-counter antifungal agents 4. Treatment failure to two oral generic antifungal agents
Oxtellar XR™	Coverage requires documentation to support the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic oxcarbazepine (Trileptal) Or Currently stable on Oxtellar XR for the treatment of seizures
Oxycontin®, Oxycodone ER	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.

Ozempic®	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or Bydureon Bcise, Byetta, Trulicity and Victoza
Palynziq™	Coverage requires documentation to support the following: 1. Diagnosis of phenylketonuria 2. Age ≥ 18 years old 3. Following a phenylalanine-restricted diet 4. Phenylalanine concetration ≥ 600 umole/liter 5. Trial and failure of Kuvan (Requires prior authorization)
paroxetine mesylate (Brisdelle™)	Requires trial/failure of generic paroxetine (Paxil) and generic venlafaxine (Effexor, Effexor XR or venlafaxine ER.
Pennsaid® 2%	Coverage will be provided after all of the following have been met: 1. Diagnosis of osteoarthritis of the knee. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs. 3. Trial of generic Pennsaid 1.5% topical solution.
Pexeva®	Requires trial/failure of at least three generic or preferred antidepressant agents, one of which must be generic paroxetine (Paxil)
phenoxy-benzamine HCl (Dibenzyline)	Coverage requires a diagnosis of pheochromocytoma or paraganglioma and the member is at least 18 years of age and older.
Picato®	Coverage requires documentation to support the following: 1. Diagnosis of actinic keratosis 2. Trial and treatment failure of 3 different treatment courses of cryotherapy or phototherapy 3. Trial and treatment failure of two generic or preferred alternatives which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara) Approve for 3 months Renewal criteria: Documentation of recurrence and/or new lesions Renewal approval: 3 months
Pomalyst®	Coverage will be provided when all of the following have been met: 1. Diagnosis of Multiple myeloma 2. Have received at least 2 prior therapies including an immunomodulatory agent (ex. thalidomide, lenalidomide) and a proteasome inhibitor (ex. bortezomib) 3. Disease progression within 60 days of completion of last therapy 4. Using in combination with dexamethasone unless contraindicated or not tolerated. 5. The prescriber is a hematologist or an oncologist. Renewal requires a record (chart notes) documenting the absence of disease progression.

Praluent™	Coverage requires attestation to support the following: 1. Diagnosis heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease 2. Prescribed by or in consultation with cardiologist, endocrinologist or board certified lipidologist 3. Trial of one high intensity statin 4. Members with statin intolerance (skeletal muscle related symptoms) must have tried generic Crestor and generic Lipitor Or 5. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)
pramipexole dihydrochloride (Mirapex® ER)	Coverage requires all of the following be met: 1. Diagnosis of Parkinson's disease 2. Trial and treatment failure of generic Mirapex immediate release
Pregnyl®	Coverage of the requested drug is provided when all the following are met: 1. The treatment is being provided by a board -certified infertility specialist. 2. It is being prescribed in accordance with generally accepted medical practice. 3. The members benefit provides for coverage for infertility medications. For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males. Or 2. Prepubertal cryptorchidism not caused by anatomic obstruction
Prestalia®	Coverage requires the following: 1. Trial and failure of a preferred ACE inhibitor and calcium channel blocker combination (example: generic Lotrel (amlodipine/benazepril)). 2. Trial and failure of the individual agents, perindopril and amlodipine used in combination at doses similar to the combination product.
Procrit®	Coverage requires all of the following be met: 1. FDA approved indication 2. Hemoblogin less than 10 g/dl Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.
Procysbi™	Coverage will be provided for the treatment of nephropathic cystinosis, in patients who have had a positive response to therapy with oral cysteamine (Cystagon) but have experienced intolerable side effects.

Promacta® tablet	Approval for coverage requires either 1, 2 or 3: 1. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 100,000 mcL) for ≥ 3 months and requires all of the following: a. Age ≥ 1-year-old. b. Prescribed by a hematologist or in consultation with a hematologist. c. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins or splenectomy. d. Current platelet count is < 20,000 mcL or <30,000 mcL and symptoms of active bleeding. e. Dose is < 75 mg/day. Or 2. Diagnosis of thrombocytopenia with chronic hepatitis C and requires all of the following: a. ≥18 years of age. b. Platelets <75,000 mcL. c. Initiating antiviral therapy with pegylated interferon and ribavirin. Or 3. Diagnosis of severe aplastic anemia and requires all of the following: a. ≥ 18 years of age b. Diagnosis confirmed by, or in consultation with a hematologist c. Current platelets ≤ 30,000/mcL d. Insufficient response to antithymocyte globulin based immunosuppressive therapy Coverage for renewal of therapy is provided in patients who meet ALL the following criteria: 1. Recent platelet count between 50,000 and 200,000/mcL OR for platelet counts outside this range, dosage has been adjusted accordingly to FDA labeled recommendations. 2. Dose does not exceed recommended maximum for indication.
Pulmozyme®	Coverage requires documentation to support a diagnosis of cystic fibrosis
Qnasl®	Requires trial and failure/intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase). 2. Generic flunisolide (Nasarel). 3. Nasacort (over-the-counter)
Qbrexza™	Coverage requires documentation to support the following: 1. Treatment of primary axillary hyperhidrosis 2. Age ≥ 9 years of age 3. 3. Trial of Drysol 4.
Qsymia®	Coverage requires documentation of the following: 1. 18 years and older 2. Documentation of BMI ≥ 30, or ≥ 27 with one weight related co morbid condition. 3. Current weight (within 30 days) must be submitted to the plan for review. 4. Documentation of concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products 6. Trial and failure of generic phentermine. Continued coverage may be authorized for members who provide documentation of weight loss of at least 5% during the first 6 months of treatment. Continued coverage of Qsymia will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline.

Qudexy™ XR	Coverage requires documentation to support the following 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives, one of which must be generic topiramate (Topamax) Or Currently stable on Qudexy XR for the treatment of seizures Or 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to 3 generic alternatives for the treatment of migraine prevention, one of which must be generic topiramate (Topamax).
Quillichew ER™	Coverage of the requested drug is provided when all the below criteria are met: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD. 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation. 3. Or physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, extended release methylphenidate (Metadate CD), generic amphetamine-dextroamphetamine (Adderal XR).
Quillivant XR™	Coverage of the requested drug is provided when all the below criteria are met: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD. 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation. 3. Or physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, extended release methylphenidate (Metadate CD), generic amphetamine-dextroamphetamine (Adderal XR).
Ragwitek™	Coverage will be provided when all of the following have been met: 1. Diagnosis of short ragweed pollen induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist.
raloxifene (Evista®)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age and post-menopausal. 2. The medication is being used for prevention of primary breast cancer in members classified as high risk. 3. Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE)
Rasuvo™	Coverage requires a diagnosis of rheumatoid arthritis, juvenile rheumatoid arthritis, or psoriasis and trial and failure of oral methotrexate and intramuscular methotrexate.
Ravicti™	Coverage will be provided for the management of patients with urea cycle disorders who cannot be managed by dietary protein restriction and /or amino acid supplementation alone.

Rayos®	Coverage requires all of the following be met: 1. Diagnosis of rheumatoid arthritis 2. Trial or intolerance of two systemically absorbed generic oral corticosteroids, one of which must be prednisone 3. An explanation why delayed release formulation is expected to work if prednisone immediate release did not.
Relistor® tablet	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza
Repatha™	Coverage requires attestation to support the following: 1. Diagnosis of primary hyperlipidemia, heterozygous or homozygous familial hypercholesterolemia or established cardiovascular disease 2. Prescribed by or in consultation with cardiologist, endocrinologist or board certified lipidologist 3. Trial with one high intensity statin 4. Members with statin intolerance (skeletal muscle related symptoms) must have tried generic Crestor and generic Lipitor Or 5. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)
Revatio® oral suspension	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) when the member is unable to swallow tablets/capsules.
Rexulti®	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone), one of which must be generic aripiprazole (Abilify).
Rhopressa®	Coverage requires documentation to support the following: 1. Diagnosis of glaucoma or ocular hypertension. 2. Trial of three preferred medications (examples include Xalatan, Lumigan, timolol)
risedronate sodium tablet (Actonel®)	Requires documentation that the member tried and failed or not tolerated treatment with generic alendronate (Fosamax), or generic ibandronate (Boniva).
risedronate sodium delayed release tablet (Atelvia®)	Coverage requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate)
Rozerem®	Requires treatment failure of 3 out of 4 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), or trazodone (Desyrel).

Rubraca™	Coverage requires documentation to support the following: 1. Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer 2. Documentation of deleterious BRCA mutation (Germline and/or somatic) as detected specifically by FDA-approved companion diagnostic test: FoundationFocus CDxbrca. 3. Previous treatment with two or more chemotherapies Or Maintenace treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy Initial 1 year Renewal criteria: Annual renewal: continuation of therapy until disease progression or intolerable toxicity occurs.
Ruconest®	Coverage requires documentation to support the following: 1. Diagnosis of treatment of acute attacks of type 1 or type 2 hereditary angioedema (HAE) 2. Diagnosis of HAE must be confirmed by genetic testing or with all the following laboratory findings a. Normal C1q levels b. C4 levels below the limits of the laboratory's normal reference range c. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range Or 1. For short-term prophylaxis a. Treatment failure of an attenuated androgen (such as Danocrine (danazol) or Oxandrin (oxandrolone)
Rydapt®	Coverage requires documentation of the following: 1. Diagnosis of acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test. 2. Using in combination with cytarabine and daunorubicin induction and cytarabine consolidation Or 3. Diagnosis of mast cell leukemia (MCL)
Rytary™	Coverage requires trial and treatment failure of generic Sinemet CR.
Sabril® tablet	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and treatment failure of three generic alternatives for seizure 3. Trial of Sabril powder Or Diagnosis of infantile spasms
Sancuso®	Coverage requires documentation to support the following: 1. Using for prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy. 2. Documented treatment/failure with generic ondansetron (Zofran)/ODT and generic granisetron (Kytril). Initial approval: 1 year Renewal requires documentation of continuation of chemotherapy

Sandostatin® LAR®/Depot	Coverage requires documentation to support the following: 1. Diagnosis of acromegaly, carcinoid tumors or vasoactive intestinal peptide tumors(VIPomas). 2. Previously tried, responded and tolerated generic immediate release octreotide
Saphris®	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone).
Savella®	Coverage requires documentation to support the following 1. Diagnosis of fibromyalgia 2. Treatment failure or intolerance to gabapentin 3. Treatment failure or intolerance to 3 of the following: a. Tricyclic antidepressant b. Selective serotonin reuptake inhibitor (SSRI) c. Serotonin norepinephrine reuptake inhibitor (SNRI) d. Cyclobenzaprine (Flexeril) e. Tramadol (Ultram)
Saxenda®	Coverage requires documentation of the following: 1. 18 years and older 2. Documentation of BMI ≥ 30, or ≥ 27 with one weight related co morbid condition. 3. Current weight (within 30 days) must be submitted to the plan for review. 4. Documentation of concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Continued coverage (up to 12 months) may be authorized for members who provide documentation of weight loss of at least 4% during the first 4 months of treatment. Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 4% weight loss from baseline.
Signifor®	Coverage requires documentation to support the following: 1. Treatment of hypercortisolism as a result of endogenous Cushing's syndrome 2. Surgical treatment has not been effective or is not an option 3. Treatment failure or intolerance to ketoconazole or mitotane, unless contraindicated
Signifor® LAR	Coverage requires documentation to support the following: 1. Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option 2. Trial of one preferred product used for acromegaly Or 1. Treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative
Siklos®	Coverage requires documentation to support the following: 1. Diagnosis of sickle cell anemia 2. Age ≥ 2 years' old 3. Unable to swallow capsules
sildenafil citrate tablet (Revatio®)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).

sildenafil (Viagra®)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Silenor®	Coverage requires documentation to support the following: 1. Trial and treatment failure or intolerance to generic Ambien (zolpidem) 2. Trial and treatment failure or intolerance to generic Desyrel (trazodone) 3. Trial and treatment failure or intolerance to generic Sinequan (doxepin) 4. Trial and treatment failure or intolerance to generic Sonata (zaleplon)
Simponi®	**Simponi 50 mg**: Coverage is provided for members 18 years of age or older for the treatment of: 1. Ankylosing spondylitis in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Cosentyx, Enbrel, or Humira. 2. Moderate to severe rheumatoid arthritis in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR. 3. Psoriatic arthritis in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Cosentyx, Enbrel, Humira or Stelara. **Simponi 100 mg:** Coverage is provided for the treatment of ulcerative colitis in members 18 years of age or older who have experienced treatment failure of or intolerance to an adequate course of systemic corticosteroids or immunomodulatory medication and Humira.
Sirturo™	Coverage requires documentation to support the following: 1. 18 years of age or older 2. Treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB)
Sitavig®	Coverage requires documentation to support the following: Trial and failure of all of the following: 1. Generic oral acyclovir (Zovirax) 2. Generic valacyclovir (Valtrex).
sodium phenylbutyrate tablet (Buphenyl®)	Coverage will be provided for the diagnosis of any Chronic Urea Cycle Disorder (except NAGS deficiency) not managed by dietary protein restriction and or amino acid supplementation alone when prescribed by a specialist.
Soliqua™	Coverage requires documentation to support the following: 1. Diagnosis of type II diabetes mellitus. 2. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 3. Trial for at least 3 months of the preferred medication, Xultophy.

Somatuline® Depot	Coverage of the requested drug will be provided when all the following criteria are met: 1. Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option. 2. Prescribing physician is an endocrinologist Or 1. Diagnosis of gastroenteropancreatic neuroendocrine tumors 2. Prescribing physician is an oncologist or a gastroenterologist. Or 1. Diagnosis of carcinoid syndrome 2. Prescribed by an oncologist or gastroenterologist
Somavert®	Coverage requires documentation to support the following: Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option
Soolantra®	Coverage requires documentation to support the following: Trial and failure of all of the following: 1. Generic topical metronidazole. 2. Generic topical sulfacetamide 10%-sulfur 5%. 3. Generic oral tetracycline, generic doxycycline or generic minocycline.
Sovaldi™	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Provide a recent fibrosis score (measure of liver damage) 4. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 5. Documentation of previous treatment experience for Hepatitis C 6. Counseling on avoidance of alcohol 7. Patient and physician must attest to compliance while taking the treatment regimen 8. Trial of preferred medication: Epclusa or Zepatier Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier
Spritam®	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Member is unable to swallow tablets or capsules 3. Trial of 3 generic or preferred alternatives, one of which must be generic levetiracetam (Keppra) solution Or 1. Stable on medication for the treatment of seizures.
Sprycel®	Coverage is provided for the treatment of the FDA approved indications.

Staxyn®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Steglujan™	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial and treatment failure of Qtern (dapagliflozin/saxagliptin)
Stelara®	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Treatment with phototherapy or photo chemotherapy was ineffective, contraindicated, or not tolerated. 3. Treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated. (Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin). Or 1. Diagnosis of psoriatic arthritis 2. Treatment with one oral systemic agent for psoriatic arthritis was ineffective or not tolerated, unless all are contraindicated. (Examples to systemic agents include, but are not limited to, cyclosporine, methotrexate and leflunomide). Or 1. Crohn's disease: treatment of adult patients with active Crohn's disease 2. Conventional therapy (examples: corticosteroids, immunomodulators) has been ineffective, contraindicated or not tolerated based on clinical documentation
Stendra®	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Stivarga®	Coverage requires documentation of the following: 1. Diagnosis of metastatic or unresectable gastrointestinal stromal tumors and disease progression or intolerance to treatment with imatinib and sunitinib. Or 2. Diagnosis of metastatic colorectal cancer (mCRC) and prior treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti- VEGF therapy, and, if RAS wild type, an anti-EGFR therapy Or 3. Treatment of hepatocellular cancer in patients who have previously been treated with sorafenib. Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.
Strensiq™	Coverage requires all of the following be met: 1. Diagnosis of perinatal/infantile-and juvenile-onset hypophosphatasia. 2. < 18 years old at onset of symptoms. 3. Diagnosis must be made by or in consultation with a geneticist, metabolic specialist, endocrinologist or bone and mineral specialist

Striant®	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency
Subsys®	Coverage requires documentation to support the following: 1. Documentation supporting that medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose narcotics 3. Currently receiving a long acting narcotic 4. Treatment failure or intolerance to oral immediate release narcotics (morphine IR, oxycodone IR, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq
Sumavel® DosePro	Coverage requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).
Sutent®	Coverage requires documentation to support following: 1. Age ≥ 18 years' old 2. Treatment of advanced renal cell carcinoma Or 1. Treatment of gastrointestinal stromal tumor (GIST) 2. Disease progression or intolerance to imatinib (Gleevac) Or Treatment of progressive, well-differentiated pancreatic neuroendocrine tumors in patients with unresectable locally advanced or metastatic disease. Or Adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy
Symdeko®	Coverage requires documentation to support the following: 1. Age > 12 years' old 2. Diagnosis of cystic fibrosis (CF) 3. Presence of two copies of the F508del mutation OR at least one mutation in the CTFR gene that is responsive to Symdeko as confirmed by genetic test 4. Prescribed by a cystic fibrosis expert Initial authorization period: 1 year Renewal requires documentation of improvement in CF symptoms

Symproic®	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza
Syprine®	Coverage of the requested drug is provided when all the following criteria are met: 1. Diagnosis of Wilson's disease 2. Trial of a preferred D-penicillamine product
Taclonex® topical suspension	Coverage requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid (ex. generic Diprolene ointment, generic Psorcon, or generic Temovate) And 2. Using in combination with generic Dovonex
Tafinlar®	Coverage requires documentation of the following: Monotherapy: 1. Diagnosis of unresectable or metastatic melanoma 2. Presence of BRAF V600E mutations In combination with Mekinist (trametinib) 1. Diagnosis of unresectable or metastatic melanoma 2. Presence of BRAF V600E or V600K mutations Or 1. Presence of BRAF V600 E mutation 2. Diagnosis of either metastatic non-small cell lung cancer or diagnosis of advanced or metastatic anaplastic thyroid cancer (ATC)
Taltz®	Coverage requires the following be met: 1. Age ≥ 18 years' old 2. Diagnosis of psoriasis 3. Trial and failure or contraindication to phototherapy or photochemotherapy 4. Trial and failure or intolerance to at least one generic oral systemic agent for plaque psoriasis (i.e. cyclosporine, methotrexate, Acitretin) 5. Trial and failure or intolerance to two of the following: Cosentyx, Humira, Otezla or Stelara Or 1. Diagnosis of psoriatic arthritis 2. Trial and failure or intolerance to one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDS include methotrexate, sulfasalazine, azathioprine) 3. Trial and failure or intolerance to two of the following: Cosentyx, Enbrel, Humira, Stelara.

Tagrisso™	Coverage requires documentation of the following: 1. Diagnosis of metastatic epidermal growth factor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. 2. Progression on or after EGFR tyrosine kinase inhibitor (TKI) therapy. Or 1. Diagnosis of metastatic NSCLC 2. Presence of EGFR exon 19 deletions or exon 21 L858R mutation Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.
tamoxifen	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age. 2. The medication is being used for prevention of primary breast cancer in members classified as high risk. 3. Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE)
Tanzeum™	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or Bydureon Bcise, Byetta, Trulicity and Victoza
Tarceva®	Coverage is provided for the treatment of the FDA approved indications.
Tasigna®	Coverage is provided for the treatment of the FDA approved indications.
Tavalisse™	Coverage requires documentation to support the following: Diagnosis of chronic immune thrombocytopenia (IT) and persistent thrombocytopenia (platelet count < 100,000mcl) for ≥ 3 months and all of the following: 1. Age ≥ 18 years old 2. Prescribed by or in consultation with a hematologist 3. Trial and treatment failure or not a candidate for treatment with corticosteroids, immunoglobulins or splenectomy 4. Current platelet count is < 20,000 mcl or < 30,000 mcl and symptoms of active bleeding 5. Trial of Promacta
Technivie™	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 4 AND without cirrhosis, and only in combination with ribavirin 3. Provide a recent fibrosis score (measure of liver damage) 4. Recent test results showing the amount of hepatitis C virus in the blood (HCV-RNA level) 5. Documentation of previous treatment experience for Hepatitis C 6. Counseling on avoidance of alcohol 7. Patient and physician must attest to compliance while taking the treatment regimen 8. Trial of preferred medication: Epclusa or Zepatier Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier

Testosterone, topical Androgel®, generic Androgel®, Androderm®	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.
Testosterone, topical generic Axiron®, Fortesta® generic Testim®, Testosterone 10mg (2%) Testosterone 30mg Testosterone 50mg (1%) Vogelxo™	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.
tetrabenazine (Xenazine®)	Coverage will be provided when the following are met: 1. Diagnosis of chorea associated with Huntington's disease. 2. Documentation of the CYP2D6 genotype of the patient will be required for doses above 50 mg per day.
Thiola®	Coverage provided when all of the following have been met: 1. For the prevention of cystine stone formation in members ≥ 9 years old. 2. Urinary cystine concentration > 500mg/day. 3. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalinization.
Tibsovo®	Coverage requires documentation of the following: FDA approved indications
Tivorbex™	Coverage requires documentation to support the following: 1. Diagnosis of acute pain 2. Trial and treatment failure of oral indomethacin 3. Trial and treatment failure of two other oral preferred NSAIDs
Tobi® Podhaler™	Coverage is provided when the following criteria are met: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa 2. Trial and failure of generic tobramycin inhalation nebulization solution.
Topiramate ER	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) Or Currently stable on Topiramate ER for the treatment of seizures

	Or 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to three generic alternatives for the treatment of migraine prevention, one of which must be generic Topamax
Toviaz®	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies.
Tracleer®	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Tradjenta®	Coverage requires documentation to support the following: 1. Trial of one generic oral diabetes drug (such as metformin) 2. Trial of both Januvia and Onglyza
Tremfya™	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Trial and failure of Humira
Treximet®	Coverage requires documentation to support the following: 1. Trial of generic sumatriptan (Imitrex) and naproxen used in combination. 2. Trial of a second generic triptan (Maxalt, Amerge, Zomig/ZMT)
Trintellix®	Requires trial and failure of at least three generic or preferred antidepressant agents
Trokendi XR™	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least three generic alternatives, one of which is generic topiramate (Topamax) Or Currently stable on Topiramate ER for the treatment of seizures Or 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to three generic alternatives for the treatment of migraine prevention, one of which must be generic Topamax
Tykerb™	Coverage is provided for the treatment of the FDA approved indications.
Tymlos™	Coverage requires documentation to support the following: 1. Treatment of postmenopausal women with osteoporosis 2. Patient has tried and failed or has a contraindication to a generic bisphosphonate (generic Fosamax, generic Boniva and generic Actonel). Tymlos will be approved for a maximum of 2 years

Tyvaso®	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Uceris™	Coverage requires documentation to support the following: 1. Treatment of active, mild to moderate ulcerative colitis 2. Trial and treatment failure of two oral, locally active corticosteroids, one of which is Entocort EC™ (budesonide).
Uceris™ foam	Coverage requires documentation to support the following: 1. Trial of a preferred corticosteroid enema or foam 2. Trial of generic rectal mesalamine.
Uloric®	Requires treatment failure, intolerance or contraindication with generic allopurinol (Zyloprim).
Uptravi™	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Valchlor™	Coverage requires documentation to support the following: 1. Diagnosis of Stage 1A or 1B mycosis fungoides type cutaneous T cell lymphoma 2. Trial of photo therapy or total skin electron beam therapy 3. Trial of carmustine or topical retinoid Initial approval: 1 year Renewal requires documentation of a positive clinical response to treatment.
Varubi™	Coverage will be provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril). 2. Preferred NK1 antagonist (ex. Emend). 3. Glucocorticoid (dexamethasone) Initial approval 1 year Renewal requires documentation of continuation of chemotherapy
Vascepa®	Coverage is provided when all the following criteria are met: 1. Trial of generic gemfibrozil (Lopid). 2. Trial of generic fenofibrate (Tricor, Trilipix, Antara) 3. Trial of generic Lovaza
Vecamyl®	Coverage requires a trial with all of the following drug classes: 1. Diuretic 2. Beta-Blocker 3. Ace-inhibitor 4. Angiotensin II receptor blocker 5. Calcium channel blocker
Venclexta™	Coverage requires documentation to support the following: Treatment of FDA approved indications. Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity

Ventavis®	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
Verzenio™	Coverage requires documentation to support treatment of FDA approved indications.
Vesicare®	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies.
Viberzi™	Coverage requires documentation to support the following: 1. Diagnosis of Irritable Bowel Syndrome with diarrhea (IBS-D) 2. Trial of all of the following: a. Loperamide b. Antispasmodic (ex. Dicyclomine, hyoscyamine) c. Tricyclic antidepressant (ex. nortriptyline)
Viibryd®	Requires trial and failure of at least three generic or preferred antidepressant agents
Vivlodex™	Coverage will be provided when all the following have been met: 1. Diagnosis of osteoarthritis. 2. Trial and failure of generic meloxicam 3. Trial and failure of two other preferred oral NSAIDs.
Vosevi®	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Trial and failure to preferred medication: Epclusa or Zepatier 3. For patients with chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection that have failed treatment regimen containing an NS5A (nonstructural protein 5A) inhibitor and have no liver damage or have liver damage and showing no symptoms from the damage. 4. For patients with chronic hepatitis C genotype 1a or 3 that have previously failed sofosbuvir containing regimen without an NS5A inhibitor and have no liver damage or have liver damage and showing symptoms of the damage. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier
Votrient®	Coverage is provided for the treatment of the FDA approved indications.
Vraylar™	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone).
Vyzulta™	Coverage requires documentation to support the following: 1. Diagnosis of elevated intraocular pressure 2. Trial of all preferred medications (generic Xalatan, generic Lumigan, Travatan Z)
Xalkori®	Coverage requires documentation of the following: 1. Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test Or 2. Metastatic NSCLC whose tumors are ROS1-positive as confirmed by a histological test

	Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.
Xeljanz®, Xeljanz® XR	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis in adults 2. Trial and failure of one DMARD (examples of DMARDs include methotrexate, sulfasalazine, azathioprine) Or 1. Diagnosis of psoriatic arthritis 2. Trial and failure of one disease-modifying antirheumatic drug (DMARDs) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine 3. Trial and failure or intolerance to two of the following: Cosentyx, Enbrel, Humira or Stelara Or 1. Diagnosis of ulcerative colitis 2. Trial and treatment failure or intolerance to conventional therapies (corticosteroids, immunomodulator) 3. Trial and treatment failure or intolerance to Humira
Xermelo™	Coverage requires documentation to support the following: 1. Diagnosis of carcinoid syndrome diarrhea 2. Age ≥ 18 years' old 3. Trial and treatment failure of somatostatin analog (SSA) (octreotide, lanreotide) 4. Using in combination with SSA.
Xifaxan® 550mg	Coverage requires documentation to support the following: 1. Diagnosis of Irritable Bowel Syndrome with diarrhea (IBS-D) 2. Trial of all of the following: a. Loperamide b. Antispasmodic (ex. Dicyclomine, hyoscyamine) c. Tricyclic antidepressant (nortriptyline) or SSRI (Paxil, Zoloft) Approval length: 1 month Or 1. Diagnosis of Hepatic encephalopathy 2. Trial of lactulose
Xolegel®	Coverage requires documentation to support the following: 1. 12 years of age or older 2. Treatment of seborrheic dermatitis 3. Treatment failure or intolerance to three generic preferred topical agents, one of which must be ketoconazole

Xuriden™	Coverage of the requested medication requires all of the following be met: 1. Diagnosis of Hereditary Orotic Aciduria. 2. Prescribed by or in consultation with an endocrinologist or geneticist. 3. Submission of baseline CBC with differential. 4. Submission of baseline urine level of orotic acid
Xyrem®	Requires a diagnosis of narcolepsy and 1 or 2: 1. Cataplexy demonstrated by supporting chart documentation or sleep studies. 2. Excessive daytime sleepiness demonstrated by supporting chart documentation or sleep studies when (a and b): a. Modafinil in doses up to 400 mg daily has been ineffective, not tolerated or contraindicated. b. At least one other generic or preferred treatment, such as methylphenidate or dextroamphetamine, has been ineffective, not tolerated or is contraindicated. Xyrem will not be approved if: 1. Patient is being treated with sedative hypnotic agents, other CNS depressants or using alcohol. 2. Patient has a history of drug abuse. 3. Patient has succinic semialdehyde dehydrogenase deficiency.
Yonsa®	Coverage requires documentation of the following: FDA approved indications
Zejula™	Coverage requires documentation of the following: Medication is being used for treatment of adult patients with recurrent ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity
Zelboraf®	Coverage requires documentation of the following: 1. 2. Diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation. Or 3. Diagnosis of Erdheim-Chester Disease with BRAF V600E mutation.
Zembrace™ SymTouch™	Coverage requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).

Zepatier™	Coverage requires documentation of the following: 1. Age 18 years or older 2. Diagnosis of Chronic Hepatitis C genotype 1 or 4 3. For genotype 1a patients, test results for NS5a resistance-associated polymorphisms 4. Provide a recent fibrosis score 5. Must have a recent HCV-RNA level provided 6. Documentation of previous treatment experience for Hepatitis C 7. Counseling on alcohol abstinence 8. Patient and physician must attest to compliance while taking the treatment regimen Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.
Zetonna®	Requires trial and failure/intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase). 2. Generic flunisolide (Nasarel). 3. Nasacort (over-the-counter)
Zipsor	Coverage requires documentation to support the following: 1. Diagnosis of acute pain 2. Trial and failure of oral diclofenac 3. Trial and failure of two other preferred oral NSAIDs
Zohydro ER®	Coverage requires documentation to support the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time. 2. Trial and failure or intolerance to two of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. Note: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.
Zolinza	Coverage is provided for the treatment of the FDA approved indications.
zolpidem tartrate sublingual (Intermezzo®)	Coverage requires documentation to support the following: 1. Trial and failure, or intolerance to generic zolpidem extended release (Ambien CR) and 2. Trial and treatment failure or intolerance to generic zaleplon (Sonata). Coverage will not be approved for combination therapy with other sedative hypnotics

Zomig® nasal spray	Coverage requires trial and treatment failure or intolerance of two generic triptans (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT).
Zorvolex™	Coverage requires documentation to support the following: 1. Requires a diagnosis of acute pain or osteoarthritis. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional nonsteroidal anti-inflammatory drugs (NSAIDs).
Zuplenz® oral soluble film	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to oral Kytril (granisetron hcl) AND Zofran (ondansetron hcl)/ODT (ondansetron). Initial approval 1 year Renewal requires documentation of continuation of chemotherapy
Zurampic®	Coverage requires all of the following be met: 1. Zurampic is being used in combination with a xanthine oxidase inhibitor (XOI) for the treatment of hyperuricemia associated with gout. 2. Treatment failure or intolerance to all maximally tolerated generic and preferred XOI. 3. Serum uric acid level ≥ 6. Not to be used as a monotherapy.
Zyclara®	Coverage requires all of the following be met: 1. Diagnosis of actinic keratosis 2. Trial of 3 different treatment courses using cryotherapy or phototherapy 3. Trial of 2 topical generic or preferred agents which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara). Initial approval: 1 month Renewal criteria: Documentation of recurrence and or new lesions. Renewal approval: 1 month
Zydelig®	Coverage requires documentation of the following: 1. Prescribed by an oncologist or hematologist 2. Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab. Or 3. Relapsed follicular B-cell non-Hodgkin lymphoma (FL) and have received at least two prior systemic therapies. Or 4. Relapsed small lymphocytic lymphoma (SLL) and have received at least two prior systemic therapies.
Zykadia™	Coverage requires documentation of the following: Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.