Prior Authorization and Step Therapy Coverage Criteria

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 April 9, 2019. 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	Blue Cross coverage criteria
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)

Drug name	Blue Cross coverage criteria
Actemra SC	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis a. Age ≥ 18 years old b. Trial and treatment failure of one disease modifying anti-rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine 2. Diagnosis of juvenile idiopathic arthritis a. Age ≥ 2 years old b. Trial and treatment failure of one DMARD c. Trial and treatment failure with Humira or Enbrel 3. Diagnosis of giant cell arteritis a. Age ≥ 18 years old 4. Diagnosis of chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome a. Age ≥ 2 years old
Addyi	Coverage requires documentation to support the following: 1. Premenopausal female ≥ 18 years old. 2. Diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that 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.

Drug name	Blue Cross coverage criteria
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: Ozempic, 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, Adderall XR)

Drug name	Blue Cross coverage criteria
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, Adderall XR)

Drug name	Blue Cross coverage criteria
Afinitor	Coverage requires documentation to support the following: 1. Diagnosis of HR-positive, HER-2 negative advanced breast cancer (in combination with exemestane) 2. Previous treatment failure with letrozole or anastrozole OR 3. Treatment of progressive pancreatic neuroendocrine tumors in patients with unresectable, locally advanced or metastatic disease OR 4. Treatment of progressive, well-differentiated nonfunctional gastrointestinal or lung neuroendocrine tumors in patients with unresectable, locally advanced or metastatic disease OR 5. Treatment of advanced renal cell carcinoma after Sutent (sinutinib) or Nexavar (sorafenib) failure OR 6. Treatment of renal angiomyolipoma with tuberous sclerosis complex (TSC) not requiring immediate surgery OR 7. Treatment of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but cannot be curatively resected 8. Age > 1 year old Initial Authorization – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually

Drug name	Blue Cross coverage criteria
Afinitor Disperz	Coverage requires documentation to support the following: 1. Adjunctive treatment of partial-onset seizures associated with tuberous sclerosis complex (TSC) 2. Age > 2 years old OR 3. Treatment pf subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but cannot be curatively resected 4. Age > 1 year old Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
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

Drug name	Blue Cross coverage criteria
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)
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)

Drug name	Blue Cross coverage criteria
amphetamine sulfate (Evekeo)	Coverage will be provided when one of the following have been met. (1, 2 or 3): 1. Narcolepsy: a. ≥ 6 years of age, b. Trial of generic Adderall IR and a generic methylphenidate. 2. ADHD: (Attention deficit hyperactivity disorder) a. 3-6 years of age. i. Trial of generic amphetamine or b. ≥6rs old, i. Trial of generic amphetamine and generic methylphenidate product. 3. Obesity: a. ≥ 12 years of age, b. Documentation of BMI > 30 kg/m2, c. Documentation of lifestyle modifications, and d. Documentation of previous failed weight loss therapies.
Amrix	Coverage requires previous trial and failure of generic immediate-release cyclobenzaprine (Flexeril).
Aplenzin	Requires trial/failure of at least three generic or preferred antidepressant agents, one of which must be generic bupropion (Wellbutrin, Wellbutrin XL).

Drug name	Blue Cross coverage criteria
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 documentation to support the following: 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	Coverage requires documentation to support the following: 1. Treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) 2. Age ≥ 12 years old

Drug name	Blue Cross coverage criteria
Arikayce	Coverage requires documentation to support the following: 1. Diagnosis of mycobacterium avium complex (MAC). 2. Age ≥ 18 years old Authorization: 1 year
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).

Drug name	Blue Cross coverage criteria
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).

Drug name	Blue Cross coverage criteria
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 Initial approval length: 1 year Continued coverage will be reviewed annually and 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 5. 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

Drug name	Blue Cross coverage criteria
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 Renewal - Annually
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

Drug name	Blue Cross coverage criteria
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 to support the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test 2. Using in combination with Mektovi Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
Bravelle	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.

Drug name	Blue Cross coverage criteria
Briviact oral solution + 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 Currently stable on Briviact for the treatment of seizures
Bystolic	Coverage requires documentation to support the following: Trial and treatment failure to at least two preferred cardioselective beta blockers such as atenolol (Tenormin), metoprolol (Toprol/XL), bisoprolol (Zebeta), betaxolol (Kerlone)
Cabometyx	Coverage requires documentation to support the following: 1. Diagnosis of advanced renal cell carcinoma 2. Age ≥ 18 years old. Or 1. Diagnosis of hepatocellular carcinoma (HCC) 2. Previous treatment with sorafenib. 3. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity

Drug name	Blue Cross coverage criteria
calcipotriene + 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) 2. Using high potency topical steroid in combination with generic Dovonex
Calquence	Coverage requires documentation to support the following: 1. Diagnosis of mantle cell lymphoma (MCL) 2. Treatment failure or intolerance to at least one prior therapy Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
Caprelsa	Coverage will be provided for the treatment of patients with metastatic or unresectable locally advanced medullary thyroid cancer. Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
Carbaglu	Coverage requires documentation to support the following: 1. Treatment of hyperammonemia due to a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) 2. Deficiency must be confirmed by enzyme or DNA mutation analysis.

Drug name	Blue Cross coverage criteria
carisoprodol (Soma)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three of the following: Flexeril (cyclobenzaprine), Norflex (orphenadrine), Parafon Forte (chlorzoxazone), or Robaxin (methocarbamol).
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.
Cequa	Coverage requires documentation to support the following: Trial and treatment failure of Restasis or Xiidra.
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)
Cetrotide	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.
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.

Drug name	Blue Cross coverage criteria
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 requires documentation to support the following: 1. Prescribed by or in consultation with hepatologist or gastroenterologist 2. Treatment of bile acid synthesis disorder due to single enzyme defects (SEDs) Or 1. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestation of liver disease, steatorrhea or complications from decreased fat-soluble vitamin deficiency 2. Prescribed by or in consultation with a hepatologist or gastroenterologist

Drug name	Blue Cross coverage criteria
chorionic gonadotropin (HCG) (Novarel)	Coverage requires documentation to support the following: 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. 4. Coverage may be provided in accordance with your medical fertility benefit Or For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males. Or 2. Prepubertal cryptorchidism not caused by anatomic obstruction.

Drug name	Blue Cross coverage criteria
Cimzia	Coverage requires documentation to support the following: 1. Diagnosis of Crohn's disease 2. Age ≥ 18 years old 3. Trial and treatment failure with an oral systemic therapy (corticosteroid, immunomodulatory medication such as azathioprine, cyclosporine, methotrexate) 4. Trial and treatment failure of Humira or Stelara Or 1. Diagnosis of rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine. 4. Trial and treatment failure to two of the following: Humira, Enbrel, Actemra or Xeljanz/Xeljanz XR. Or 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure to two of the following: Humira, Enbrel or Cosentyx. Or 1. Diagnosis of psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure with one DMARD 4. Trial and treatment failure of two of the following: Humira, Enbrel, Stelara, Xeljanz/XR or Cosentyx. Or 1. Diagnosis of psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of light therapy 4. Trial and treatment failure of a generic oral systemic agent (cyclosporine, methotrexate, acitretin) 5. Trial and treatment failure to two of the following: Cosentyx, Humira, Otezla or Stelara

Drug name	Blue Cross coverage criteria
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 requires documentation to support the following: 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 Initial approval length: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline

Drug name	Blue Cross coverage criteria
Copiktra	Coverage requires documentation to support the following: 1. Diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL or small lymphocytic lymphoma (SLL)) after at least two prior therapies Or 2. Relapsed or refractory follicular lymphoma (FL) after at least two prior systemic therapies
Corlanor	Coverage requires documentation to support the following: 1. Diagnosis of heart failure with left ventricular ejection fraction ≤ 35% 2. Stable on a maximally tolerated dose of one of the following beta blockers: metoprolol succinate, carvedilol or bisoprolol
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 lefunomide) Or Age 18 years or older and diagnosis of ankylosing spondylitis

Drug name	Blue Cross coverage criteria
Cotellic	Coverage requires documentation to support the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation 2. Using in combination with Zelboraf Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal - Annually
Crinone 8%	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.
Cuvitru	Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met. 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.

Drug name	Blue Cross coverage criteria
dalfampridine ER (Ampyra)	Coverage requires documentation to support the following: 1. Diagnosis of multiple sclerosis. 2. Patient has documented difficulty walking, resulting in significant limitations of instrumental activities of daily living. 3. Clinical notes are provided documenting two measurements with variability within 10% demonstrating the patient is able to walk 25 feet in 8-45 seconds. The faster time of the two measurements will serve as the baseline value. Ambulatory function assessed with the timed 25-foot walk (T25FW). Initial approval length: 6 months Renewal requires the following: 1. Improvement in walking speed by at least 20% as assessed by the timed 25-foot walk test 2. Activities of daily living have improved
Daliresp	Coverage requires documentation to support the following: 1. Diagnosis of chronic obstructive pulmonary disease (COPD). 2. Trial of inhaled long-acting beta agonist (LABA) 3. Trial of an inhaled anticholinergic medication 4. Trial of an inhaled corticosteroid
Daraprim	Coverage is provided for the treatment of toxoplasmosis when used conjointly with a sulfonamide

Drug name	Blue Cross coverage criteria
Daurismo	Coverage requires documentation to support the following: Treatment of newly diagnosed acute myeloid leukemia (in combination with low-dose cytarabine) in adult patients who are ≥ 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy. Limitations of use: Has not been studied in patients with severe renal impairment or moderate to severe hepatic impairment.
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).
dextroamphetamine + amphetamine (Adderall XR)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to brand name Adderall XR.
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

Drug name	Blue Cross coverage criteria
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 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).

Drug name	Blue Cross coverage criteria
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 calcineurin 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)	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 IR 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).

Drug name	Blue Cross coverage criteria
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 to support the following: 1. Age ≥ 12 years old 2. Prescribed by a dermatologist or allergist 3. Treatment of moderate to severe atopic dermatitis in adults whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable 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 or generic 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). Or 1. Diagnosis of eosinophilic asthma 2. Eosinophil count > 150 3. Using in addition to other asthma medications 4. Prescribed by an allergist/immunologist or pulmonologist 5. Age ≥ 12 years old Or 1. Diagnosis of oral corticosteroid dependent asthma 2. Using in addition to other asthma medications 3. Prescribed by an allergist/immunologist or pulmonologist 4. Age ≥ 12 years old

Drug name	Blue Cross coverage criteria
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, Adderall XR).
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.

Drug name	Blue Cross coverage criteria
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 requires documentation to support the following: 1. Diagnosis of HIV 2. Currently receiving antiretroviral therapy (ART) 3. Documentation of the medical complication caused by excess abdominal fat 4. Medical complication due to excess abdominal fat is not responsive to conventional therapy. Initial approval: 6 months Renewal: Requires documentation indicating a decrease in waist circumference and reduction of complications caused by excess abdominal fat
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)).

Drug name	Blue Cross coverage criteria
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 documentation to support 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. Trial and treatment failure of prednisone or prednisolone.

Drug name	Blue Cross coverage criteria
Emgality	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
Enbrel	Coverage requires documentation to support the following: 1. Rheumatoid arthritis or psoriatic arthritis 2. Age ≥ 18 years of age 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chlorquine, cyclosporine, gold and penicillamine. Or 1. Ankylosing spondylitis 2. Age ≥ 18 years old Or 1. Psoriasis 2. Age ≥ 4 years old 3. Trial of light therapy (unless contraindicated) 4. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) 5. Trial and treatment failure with Humira (age appropriate) Or 1. Juvenile idiopathic arthritis 2. Age ≥ 2 years old 3. Trial and treatment failure of one DMARD. Examples include methotrexate, sulfasalazine, azathioprine.

Drug name	Blue Cross coverage criteria
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
Endometrin	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 Crinone 4. The members benefit provides coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit
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)

Drug name	Blue Cross coverage criteria
Epclusa, Sofosbuvir + Velpatasvir	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. Documentation of previous treatment experience for Hepatitis C 4. Documentation of compensated or decompensated cirrhosis 5. Prescribed by a hepatologist, gastroenterologist, or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.
Epidiolex	Coverage requires documentation to support the following: 1. Diagnosis of Lenox-Gastaut or Dravets syndrome 2. Trial and treatment failure of at least 2 generic alternatives
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%

Drug name	Blue Cross coverage criteria
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.
Erivedge	Coverage requires documentation to support the following: 1. Diagnosis of locally advanced basal cell carcinoma 2. Carcinoma occurred again following surgery OR the member not able to have surgery 3. Not a candidate for radiation Or 1. Diagnosis of metastatic basal cell carcinoma 2. Not a candidate for radiation Initial approval: 1 year Renewal requires documentation showing no disease progression Renewal – Annually.

Drug name	Blue Cross coverage criteria
Erleada	Coverage requires documentation to support the following: Treatment of non-metastatic, castration-resistant prostate cancer
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 or generic Elidel)
Exjade	Coverage requires documentation to support the following: 1. Chronic iron overload due to transfusions: 2. ≥ 2 years of age 3. Trial and failure of Desferal Or 1. Chronic iron overload in nontransfusion-dependent thalassemia syndromes: 2. ≥ 10 years of age 3. Trial and failure of Desferal.
Fabior	Coverage requires documentation to support the following: Trial and treatment failure to both generic adapalene (Differin) and generic tretinoin (Retin-A, Avita).

Drug name	Blue Cross coverage criteria
Fanapt	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone)
Farydak	Coverage requires documentation to support the following: 1. Diagnosis of multiple myeloma 2. Will be used in combination with bortezomib and dexamethasone 3. Has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (e.g. lenalidomide (Revlimid), or thalidomide (Thalomid)) Initial approval: 1 year. Renewal requires documentation showing no disease progression
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)

Drug name	Blue Cross coverage criteria
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	Coverage requires documentation to support the following: 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.
Fetzima	Requires trial/failure of at least three generic or preferred antidepressant agents.
Finacea foam	Coverage requires documentation to support a trial of all the following: 1. Generic topical metronidazole 2. Generic oral tetracycline, generic doxycycline or generic minocycline
Firazyr	Coverage requires documentation to support the following: 1. Diagnosis of treatment of acute attacks of hereditary angioedema (HAE) 2. Prescribed by an immunologist, allergist or hematologist

Drug name	Blue Cross coverage criteria
Firdapse	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Prescribed by a neurologist 3. Diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS). Initial approval: 1 year Renewal requires documentation to support improvement in muscle function/strength or documentation of stable disease. Renewal approval: Annually
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: 3 months Renewal criteria: Documentation of recurrence and or new lesions. Renewal approval: 3 months

Drug name	Blue Cross coverage criteria
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)

Drug name	Blue Cross coverage criteria
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)).
Galafold	Coverage requires documentation to support the following: 1. Diagnosis of Fabry disease. 2. Documentation of an amenable galactosidase alpha gene (GLA) variant based on in vitro assay
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.
Ganirelix Acetate (generic only)	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.
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

Drug name	Blue Cross coverage criteria
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. 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 2. 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 or improvement (i.e. elevation of AAT levels above threshold of 80 mg/dl)

Drug name	Blue Cross coverage criteria
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: Diagnosis of post-herpetic neuralgia (PHN) And 1. ≤ 65 years of age 2. Trial of generic Neurontin (gabapentin) 3. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) Or 1. ≥ 65 years of age 2. Trial of generic Neurontin (gabapentin)

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
Growth Hormone (adults) **Preferred** Genotropin Norditropin Nutropin Nutropin AQ **Non-preferred** 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): A. • Failed at least one clinically validated, clearly documented growth hormone stimulation test o 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 o 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 **(criteria continued next page)**

Drug name	Blue Cross coverage criteria
Growth Hormone (adults) (continued)	Or • 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: o Unexplained weight loss > 10% of baseline o Concomitant anti-viral therapy for the duration of treatment Or • Diagnosis of short bowel syndrome and o Receiving specialized nutritional support, which may include dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient supplements o Approval for 4 weeks of treatment Coverage for a non-preferred medication requires treatment failure to all preferred medications (Genotropin, Norditropin,and Nutropin AQ)

Drug name	Blue Cross coverage criteria
Growth Hormone (pediatrics) **Preferred** Genotropin Norditropin Nutropin Nutropin AQ **Non-preferred** 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 **(criteria continued next page)**

Drug name	Blue Cross coverage criteria
Growth Hormone (pediatrics) (continued)	Or 4. Pediatric Burn • 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 (West Syndrome) for children less than 2 years old.
Haegarda	Coverage requires documentation to support the following: 1. Diagnosis of hereditary angioedema (HAE) 2. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract. 3. Prescribed by an immunologist, allergist or hematologist

Drug name	Blue Cross coverage criteria
Harvoni, Ledipasvir + Sofosbuvir	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. Documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1 and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist Drug will be reviewed 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.

Drug name	Blue Cross coverage criteria
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. Diagnosis of post-herpetic neuralgia (PHN) 2. ≥ 65 years of age 3. Trial of generic Neurontin (gabapentin)

Drug name	Blue Cross coverage criteria
Humira	Coverage requires documentation of the following: **1. <u>Rheumatoid arthritis, juvenile idiopathic arthritis or psoriatic arthritis</u>:** 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. <u>Ankylosing spondylitis</u>** **3. <u>Psoriasis</u>** a. Age ≥ 18 years old b. Trial of light therapy (unless contraindicated) c. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) **4. <u>Crohn's Disease</u>:** 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. <u>Ulcerative Colitis</u>:** 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. <u>Hiradenitis suppurativa:</u>** 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. <u>Uveitis:</u>** a. Diagnosis of non-infectious intermediate uveitis, posterior uveitis or panuveitis. b. Prescribed by an ophthalmologist or rheumatologist c. Trial of an oral corticosteroid d. Trial of an oral immunomodulatory agent. Examples include: methotrexate, azathioprine, cyclosporine

Drug name	Blue Cross coverage criteria
hydromorphone (Exalgo)	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. Generic 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.
HyQvia	Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met. Continued coverage may be authorized by providing documentation of improvement.

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
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. Initial Approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
Iclusig	Coverage requires documentation to support the following: 1. Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I-positive Or 2. Treatment of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I-positive And 3. Age ≥ 18 years old Initial Approval - 1 year Renewal: Evidence of tumor response, no evidence of disease progression. Renewal – Annually

Drug name	Blue Cross coverage criteria
Idhifa	Coverage requires documentation to support the following: 1. Treatment of relapsed or refractory acute myeloid leukemia (AML) 2. Documentation showing an isocitrate dehydrogenase-2 (IDH2) mutation Initial approval: 1 year. Renewal requires documentation showing no disease progression Renewal – Annually
Imbruvica	Coverage requires documentation to support treatment of FDA approved indications. Authorization: 1 year Renewal: Evidence of tumor response, no evidence of disease progression
Inbrija	Coverage requires documentation to support the following: 1. Treatment of intermittent OFF episodes in patients with parkinson's disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Using in combination with carbidopa/levodopa

Drug name	Blue Cross coverage criteria
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 a 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.

Drug name	Blue Cross coverage criteria
Inveltys	Coverage requires documentation to support the following: 1. Using for the treatment of post-operative eye pain. 2. Trial and treatment failure of one preferred or generic alternative for eye pain. Approval: 1 month
Iressa	Coverage requires documentation to support the following: 1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) 2. Documentation of epidermal growth factor (EGFR) exon 19 deletions or exon 21 (l858R) 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
Jadenu	Coverage will be provided if the following criteria has been met: 1. Chronic iron overload due to transfusions: a. ≥ 2 years of age. b. Trial and failure of Desferal. Or 2. Chronic iron overload in nontransfusion-dependent thalassemia syndromes: a. ≥ 10 years of age. b. Trial and failure of Desferal

Drug name	Blue Cross coverage criteria
Jakafi	Coverage requires documentation to support the following: 1. Diagnosis of intermediate or high risk myelofibrosis 2. Refractory to 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) Or 1. Diagnosis of Polycythemia vera and all of the following: 2. Trial of hydroxyurea 3. Prescribing physician is an oncologist or hematologist Initial approval – 1 year Renewal for Myelofibrosis requires documentation of a reduction in spleen volume or a reduction in palpable spleen length Renewal for Polycythemia vera requires documentation of a reduction in phlebotomy requirements (supported by a recent CBC) Renewal - annually
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

Drug name	Blue Cross coverage criteria
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 requires documentation to support the following: 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 treatment failure of acetazolamide.

Drug name	Blue Cross coverage criteria
Kevzara	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis 2. Age ≥ 18 years old 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	Requires trial and failure of at least three generic or preferred antidepressant agents
Kineret	Coverage requires documentation to support the following: 1. Diagnosis of Rheumatoid Arthritis a. Age ≥ 18 years old b. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine c. Trial and treatment failure with two of the following: Actemra, Enbrel, Humira, Xeljanz/Xeljanz XR Or Diagnosis of Neonatal-onset multisystem inflammatory disease
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

Drug name	Blue Cross coverage criteria
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). 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. Initial authorization: 1 year Renewal Criteria**:** Renewal requires documentation of ≥ 1% reduction in HbA1c from baseline or ≥ 25% improvement in glucose tolerance. Renewal authorization: 1 year Annual renewal: Member is stable on med
Kuvan	Coverage requires documentation to support the following: 1. Treatment of phenylketonuria (PKU) 2. Following a phenylalanine-restricted diet

Drug name	Blue Cross coverage criteria
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 to support the following: 1. Diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC) 2. 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 Or Diagnosis of unresectable hepatocellular carcinoma Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity.

Drug name	Blue Cross coverage criteria
Letairis	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).
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

Drug name	Blue Cross coverage criteria
Lonsurf	Coverage requires documentation to support the following: 1. Diagnosis of metastatic colorectal cancer 2. Previous treatment with a. fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy b. anti-VEGF biological therapy 3. Test results showing RAS wild type have received treatment with an anti-EGFR therapy OR 1. Diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma 2. Previous treatment with at least 2 prior systemic therapies which included a fluoropyrimidine, a platinum, either a taxane or irinotecan and HER2/neu-targeted therapy (if appropriate) Initial approval - 1 year Renewal requires documentation showing no disease progression Renewal – Annually
Lorbrena	Coverage requires documentation to support the following: 1. Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC). 2. Disease progression while on crizotinib and at least one other ALK inhibitor for metastatic disease Or 3. Previous trial of alectinib or ceritinib

Drug name	Blue Cross coverage criteria
Luzu	Coverage requires documentation to support the following: 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 FDA 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 Renewal – Annually

Drug name	Blue Cross coverage criteria
Lyrica	Coverage requires documentation to support the following: 1. Treatment of seizures Or 2. Treatment of neuropathic pain a. If patient ≥ 65 years of age: After a trial of gabapentin. b. If patient < 65 years of age: After a trial of two of the following: gabapentin, tricyclic antidepressant or serotonin and norepinephrine reuptake inhibitors. Or 3. Treatment of non-neuropathic pain. (i.e Fibromyalgia, myalgias, myositis,low back pain): a. Treatment failure or intolerance to 3 of the following: i. Gabapentin ii. Tricyclic antidepressant iii. Selective serotonin reuptake inhibitors (SSRI) iv. Serotonin and norepinephrine reuptake inhibitors (SNRI) v. Cyclopenzaprine (Flexeril) vi. Tramadol (Ultram)
Lyrica CR	Coverage requires documentation to support the following: 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

Drug name	Blue Cross coverage criteria
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 3. Documentation of previous treatment experience for Hepatitis C 4. Trial of the preferred medication: Epclusa or Zepatier 5. 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 6. Documentation of compensated or decompensated cirrhosis 7. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure to Epclusa or Zepatier

Drug name	Blue Cross coverage criteria
Mekinist	Coverage requires documentation to support the following: 1. Diagnosis of melanoma 2. Presence of BRAF V600E or V600K mutation 3. Using as a single agent or in combination with Tafinlar (dabrafenib) Or 1. Diagnosis of metastatic non-small cell lung cancer or advanced or metastatic anaplastic thyroid cancer 2. Presence of BRAF V600 E mutation 3. Using in combination with Tafinlar (dabrafenib) Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity. Renewal - Annually
Mektovi	Coverage requires documentation to support the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test 2. Using in combination with Braftovi Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually

Drug name	Blue Cross coverage criteria
Menopur	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.
metaxalone (Skelaxin)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three of the following: Flexeril (cyclobenzaprine), Norflex (orphenadrine), Parafon Forte (chlorzoxazone), or Robaxin (methocarbamol).
metformin hcl extended release (Fortamet)	Coverage requires trial and failure of generic Glucophage XR (metformin extended release)
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). Initial approval: 1 year Continued coverage may be authorized for members by providing documentation of stability or improvement in disease

Drug name	Blue Cross coverage criteria
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)
Motegrity	Coverage requires documentation to support the following: 1. Age > 18 years of age 2. Treatment of chronic idiopathic constipation (CIC) 3. Drug-induced constipation has been ruled out 4. Member has had a trial and failure, contraindication, or intolerance to all of the following: a) Fiber b) Stimulant laxatives (to be used in combination with a stool softener) c) Osmotic laxatives d) Amitiza or Linzess. Initial Approval: 2 years. Renewal criteria: Documentation of increase in number of spontaneous bowel movements. Renewal approval: 2 years

Drug name	Blue Cross coverage criteria
Movantik	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years old 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	Coverage requires documentation to support the following: 1. Replacement therapy to treat the complications of leptin deficiency, in addition to diet, in patients with congenital or acquired generalized lipodystrophy. 2. Optimally treated with insulin 3. Optimally treated with a statin (examples include atorvastatin, simvastatin)

Drug name	Blue Cross coverage criteria
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
Namzaric	Coverage requires documentation to support the following: Already stable on memantine (Namenda) and donepezil (Aricept)
Natesto	Coverage requires documentation to support the following: 1. Diagnosis of hypogonadism 2. Two signs and symptoms specific to testosterone deficiency
Natpara	Coverage requires documentation to support the following: 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.

Drug name	Blue Cross coverage criteria
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 legs 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.

Drug name	Blue Cross coverage criteria
Ninlaro	Coverage requires documentation to support the following: 1. Diagnosis of multiple myeloma 2. Using in combination with lenalidomide and dexamethasone 3. Have received at least one prior therapy
Nityr	Coverage requires documentation of the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine
Nocdurna	Coverage requires documentation to support the following: 1. Diagnosis of nocturnal polyuria 2. Lifestyle changes have been tried (including limiting fluids, elevation of legs) 3. Treatment failure or intolerance to one generic medication for overactive bladder (OAB) 4. Trial of generic oral desmopressin
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

Drug name	Blue Cross coverage criteria
Northera	Coverage requires documentation to support the following: 1. Diagnosis of orthostatic hypotension 2. Age ≥18 years old 3. Trial and treatment failure of midodrine 4. Trial and treatment failure of fludrocortisone
Nucynta	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.

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
Nuedexta	Coverage requires documentation to support the following: 1. Diagnosis of pseudobulbar affect (PBA) 2. Documentation of an underlying neurological condition causing symptoms of PBA (ex. Multiple Sclerosis, amyotrophic lateral sclerosis, Parkinson's 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 Renewal – Annually

Drug name	Blue Cross coverage criteria
Ocaliva	Coverage requires documentation to support the following: 1. 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 2. Documented inadequate response to ursodeoxycholic acid (UDCA) such as Actigall (ursodiol) after at least one year at a dose of 13-15mg/kg/day or inability to tolerate UDCA 3. Treatment plan must include UDCA unless unable to tolerate it. Initial approval: 1 year Renewal requires member is responding to therapy Renewal authorization: Lifetime
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

Drug name	Blue Cross coverage criteria
Odomzo	Coverage requires documentation to support the following: 1. Diagnosis of locally advanced basal cell carcinoma 2. Carcinoma occurred again following surgery or radiation therapy OR member is not able to receive treatment with surgery or radiation therapy Initial approval: 1 year. Renewal requires documentation showing no disease progression Renewal – Annually
Ofev	Coverage requires documentation to support the following: 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
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)

Drug name	Blue Cross coverage criteria
Onexton	Coverage requires trial of all of the following: 1. The individual agents in combination (topical clindamycin plus benzoyl peroxide) 2. generic Duac 3. generic Benzaclin
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.

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
Orencia SC	Coverage requires documentation to support the following: 1. Diagnosis of Rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine 4. Trial and treatment failure to two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR Or 1. Diagnosis of Juvenile idiopathic arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure to one DMARD 4. Trial and treatment failure to Enbrel and Humira Or 1. Diagnosis of psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one DMARD 4. Trial and treatment failure of two of the following: Cosentyx, Enbrel, Humira, Stelara or Xeljanz/XR
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

Drug name	Blue Cross coverage criteria
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 to support the following: 1. Diagnosis of cystic fibrosis (CF) in patients with two copies of the F508del mutation confirmed by genetic test. 2. Age ≥ 2 years old 3. Prescribed by pulmonologist in a Cystic Fibrosis center Initial approval: 6 months Renewal requires documentation of improvement in Cystic Fibrosis symptoms.

Drug name	Blue Cross coverage criteria
Otezla	Coverage requires documentation of the following: 1. Psoriatic arthritis: a. ≥ 18 years of age b. Trial of oral Disease Modifying Anti-Rheumatic drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine c. Trial of one of the following: Cosentyx, Enbrel, Humira, Stelara or Xeljanz/XR Or 2. Psoriasis: a. ≥ 18 years of age b. Trial and treatment failure of one DMARD. Examples include methotrexate, cyclosporine, acitretin c. Trial of light therapy.
Otrexup	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis, juvenile rheumatoid arthritis or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable 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

Drug name	Blue Cross coverage criteria
oxandrolone (Oxandrin)	Coverage requires documentation to support the following: 1. Relief of bone pain accompanying osteoporosis Or 2. Offset protein catabolism associated with prolonged administration of corticosteroids Or 3. Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections or severe trauma or in some patients who fail to gain or maintain normal weight
Oxervate	Coverage requires documentation to support the following: Diagnosis of neurotrophic keratitis that has progressed to stage 2 or 3 Approval: 8 weeks
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

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
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)
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)

Drug name	Blue Cross coverage criteria
phenoxy-benzamine HCl (Dibenzyline)	Coverage is provided for the treatment of hypertension and sweating episodes due to pheochromocytoma: Age ≥ 18 years old **Preoperative treatment:** for members who have experienced treatment failure of or intolerance to a preferred selective alpha1-adrenergic receptor blocker (such as Cardura (doxazosin)) in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)). Approval duration: up to 14 days. **Non-preoperative treatment:** for members who have experienced treatment failure of or intolerance to TWO selective alpha1-adrenergic receptor blockers (such as Cardura (doxazosin)) where both are used in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)).
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

Drug name	Blue Cross coverage criteria
Pomalyst	Coverage requires documentation to support the following: 1. Diagnosis of Multiple myeloma 2. Used in combination with dexamethasone 3. Received at least 2 prior therapies including an immunomodulatory agent (ex. thalidomide, lenalidomide) and a proteasome inhibitor (ex. bortezomib) 4. Disease progression within 60 days of completion of last therapy Initial approval: 1 year Renewal requires documentation showing no disease progression Renewal – Annually
Praluent	Coverage requires attestation to support the following: 1. Diagnosis of 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)

Drug name	Blue Cross coverage criteria
Pregnyl	Coverage requires documentation to support the following: 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 member's benefit provides for coverage for infertility medications. 4. Coverage may be provided in accordance with your medical fertility benefit For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males. Or 2. Prepubertal cryptorchidism not caused by anatomic obstruction
Procrit	Coverage requires all of the following be met: 1. FDA approved indication 2. Hemoglobin (Hgb) 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 requires documentation to support the following: 1. Treatment of nephropathic cystinosis 2. Has had a positive response to oral cysteamine (Cystagon) but has experienced intolerable side effects

Drug name	Blue Cross coverage criteria
Promacta	Coverage requires documentation to support the following: 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 of age b. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins or splenectomy. c. Current platelet count is < 20,000 mcL or <30,000 mcL and has symptoms of active bleeding. d. 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. Or 3. Diagnosis of severe aplastic anemia and requires all of the following: a. ≥ 18 years of age b. Current platelets ≤ 30,000/mcL c. Insufficient response to antithymocyte globulin based immunosuppressive therapy Initial approval – 1 year Renewal of therapy requires ALL the following be met: 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 Renewal – Annually

Drug name	Blue Cross coverage criteria
Pulmozyme	Coverage requires documentation to support a diagnosis of cystic fibrosis
Qbrexza	Coverage requires documentation to support the following: 1. Treatment of primary axillary hyperhidrosis 2. Age ≥ 9 years of age 3. Trial of Drysol
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)
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 Initial approval length: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline

Drug name	Blue Cross coverage criteria
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 1. 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).

Drug name	Blue Cross coverage criteria
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)
Ranexa	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to both a beta-blocker (such as Toprol XL (metoprolol)) and a maintenance nitrate (such as Imdur (isosorbide mononitrate)) given around-the-clock.

Drug name	Blue Cross coverage criteria
Rasuvo	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis, juvenile rheumatoid arthritis or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate
Ravicti	Coverage requires documentation to support the following: 1. Diagnosis of urea cycle disorder 2. Trial and treatment failure of dietary protein restriction and/or amino acid supplementation 3. Trial and treatment failure of Buphenyl
Rayos	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis 2. Trial or intolerance of two systemically absorbed generic oral corticosteroids, one of which must be prednisone
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

Drug name	Blue Cross coverage criteria
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.
Revcovi	Coverage requires documentation to support the following: 1. Diagnosis of adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) 2. Prescribed by or in consultation with an immune specialist. Initial Approval - 1 year Renewal requires documentation of progress of disease status. Renewal - Annually
Rexulti	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone), one of which must be generic aripiprazole (Abilify).

Drug name	Blue Cross coverage criteria
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 DR (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 will be provided for adults for 1. Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer 2. Documentation of deleterious BRCA mutation as detected by FDA-approved test: 3. Treatment with two or more chemotherapies Or 1. For the maintenance 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 approval: 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually

Drug name	Blue Cross coverage criteria
Ruconest	Coverage requires documentation to support the following: 1. Diagnosis of treatment of acute attacks of hereditary angioedema (HAE) 2. Prescribed by an immunologist, allergist or hematologist
Rydapt	Coverage requires documentation to support 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 1. Diagnosis of mast cell leukemia (MCL) Or 1. Diagnosis of aggressive systemic mastocytosis or systemic mastocytosis with associated hematological neoplasm (SM-AHN)
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

Drug name	Blue Cross coverage criteria
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)

Drug name	Blue Cross coverage criteria
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 Initial approval length: 1 year 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's disease for whom pituitary surgery is not an option or has not been curative

Drug name	Blue Cross coverage criteria
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)

Drug name	Blue Cross coverage criteria
Simponi	Coverage requires documentation to support the following: 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Cosentyx, Enbrel or Humira Or 1. Diagnosis of Rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine. 4. Trial and treatment failure to two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR. 5. Using in combination with methotrexate Or 1. Diagnosis of Psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one DMARD 4. Trial and treatment failure of two of the following: Cosentyx, Enbrel, Humira or Xeljanz/XR Or 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one immunomodulatory medication. Examples include azathioprine, corticosteroids, cyclosporine, methotrexate. 4. Trial and treatment failure of Humira or Xeljanz

Drug name	Blue Cross coverage criteria
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).
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 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. Or 1. Diagnosis of gastroenteropancreatic neuroendocrine tumors Or 1. Diagnosis of carcinoid syndrome

Drug name	Blue Cross coverage criteria
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 a trial of all the following: 1. Generic topical metronidazole 2. 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. Trial of preferred medication: Epclusa or Zepatier 4. Documentation of previous treatment experience for Hepatitis C 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. 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

Drug name	Blue Cross coverage criteria
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.

Drug name	Blue Cross coverage criteria
Stelara	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Age ≥ 12 years old 3. Treatment with phototherapy or photo chemotherapy was ineffective, contraindicated, or not tolerated. 4. 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. Age ≥ 18 years old 3. 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.

Drug name	Blue Cross coverage criteria
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 documentation to support the following: 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 to support the following: 1. Diagnosis of hypogonadism 2. Two signs and symptoms specific to testosterone deficiency

Drug name	Blue Cross coverage criteria
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. Treatment of advanced renal cell carcinoma (RCC) Or 1. Treatment of gastrointestinal stromal tumor (GIST) 2. Disease progression or intolerance to imatinib (Gleevec) Or 1. Treatment of progressive, well-differentiated pancreatic neuroendocrine tumors in patients with unresectable locally advanced or metastatic disease. Or 1. Adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy

Drug name	Blue Cross coverage criteria
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
Sympazan	Coverage requires documentation to support the following: 1. Diagnosis of Lennox-Gastaut syndrome 2. Trial of generic clobazam solution Or Member is unable to swallow tablets/capsules
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

Drug name	Blue Cross coverage criteria
Syprine	Coverage requires documentation to support the following: 1. Diagnosis of Wilson's disease 2. Trial of or intolerance to a preferred d- penicillamine product (Depen)
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 high potency topical steroid in combination with generic Dovonex
tadalafil (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.
tadalafil (Cialis 2.5mg, 5mg)	Coverage for daily dosing requires documentation to support the following: 1. Diagnosis of Benign Prostatic Hyperplasia (BPH) 2. Trial and failure or intolerance of an alpha-blocker 3. Trial and treatment failure of a 5-alpha reductase inhibitor. May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
tadalafil (Cialis)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.

Drug name	Blue Cross coverage criteria
Tafinlar	Coverage requires documentation to support the following: 1. Diagnosis of melanoma 2. Presence of BRAF V600E or V600K mutation 3. Using as a single agent or in combination with Mekinist (trametinib) Or 1. Diagnosis of metastatic non-small cell lung cancer or advanced or metastatic anaplastic thyroid cancer 2. Presence of BRAF V600 E mutation 3. Using in combination with Mekinist (trametinib) Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity. Renewal - Annually
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.

Drug name	Blue Cross coverage criteria
Takhzyro	Coverage requires documentation to support the following: 1. Diagnosis of hereditary angioedema (HAE) 2. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract. 3. Prescribed by an immunologist, allergist or hematologist
Taltz	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure to light therapy 4. Trial and treatment failure to one generic oral systemic agent (cyclosporine, methotrexate, acitretin) 5. Trial and treatment failure to three of the following: Cosentyx, Humira, Otezla or Stelara. Or 1. Diagnosis of psoriatic arthritis 2. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD) Examples include methotrexate, sulfasalazine, azathioprine 3. Trial and treatment failure to two of the following: Cosentyx, Enbrel, Humira, Stelara or Xeljanz/XR
Talzenna	Coverage requires documentation to support the following: Diagnosis of BRCA mutated, as detected by an FDA approved test, HER2-negative locally advanced or metastatic breast cancer

Drug name	Blue Cross coverage criteria
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. Does not have a history of breast cancer 4. Does not have a family or personal history of venous thromboembolic events (VTE)
Tarceva	Coverage is provided for the treatment of the FDA approved indications.
Targretin gel	Coverage requires documentation to support the following: 1. Diagnosis of Cutaneous T-cell lymphoma 2. Topical treatment of cutaneous lesions
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

Drug name	Blue Cross coverage criteria
Tegsedi	Coverage is provided when the below criteria is met: 1. Age ≥ 18 years old 2. Diagnosis of peripheral nerve disease caused by hereditary transthyretin-mediated amyloidosis (hATTR) with a documented TTR gene mutation 3. Documentation of clinical signs and symptoms of peripheral neuropathy or autonomic neuropathy symptoms. Initial approval - 1 year. Renewal requires documentation to support a positive clinical response. Renewal approval - Annually
Testosterone, topical Androgel, generic Androgel, Androderm	Coverage requires documentation to support the following: 1. Diagnosis of hypogonadism 2. Two signs and symptoms specific to testosterone deficiency

Drug name	Blue Cross coverage criteria
Testosterone, topical generic Axiron, generic Fortesta generic Testim, Testosterone 10mg (2%) Testosterone 30mg Testosterone 50mg (1%) Vogelxo	Coverage requires documentation to support the following: 1. Diagnosis of hypogonadism 2. Two signs and symptoms specific to testosterone deficiency
tetrabenazine (Xenazine)	Coverage requires documentation to support the following: Diagnosis of chorea associated with Huntington's disease.
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 alkalization.
Tibsovo	Coverage requires documentation of the following: FDA approved indications

Drug name	Blue Cross coverage criteria
Tiglutik	Coverage requires documentation to support the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Trial of generic riluzole tablets 3. Difficulty swallowing
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.

Drug name	Blue Cross coverage criteria
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 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).
Tremfya	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) 4. Trial and treatment failure to Humira

Drug name	Blue Cross coverage criteria
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 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 one of which must be generic Topamax
Tykerb	Coverage is provided for the treatment of the FDA approved indications

Drug name	Blue Cross coverage criteria
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 foam	Coverage requires documentation to support the following: 1. Trial of a preferred corticosteroid enema or foam 2. Trial of generic rectal mesalamine.
Uloric	Coverage requires documentation to support the following: Trial and treatment failure with allopurinol (Zyloprim)
Uptravi	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).

Drug name	Blue Cross coverage criteria
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.
vardenafil (Levitra)	May be covered for the diagnosis of erectile dysfunction dependent on the plans benefit with quantity limit restrictions.
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 requires documentation to support the following: Treatment of severe hypertriglyceridemia (≥ 500mg/dL)

Drug name	Blue Cross coverage criteria
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: FDA approved indications Initial approval: 1 year. Renewal requires documentation showing no disease progression Renewal – Annually
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 (Over Active Bladder) therapies.

Drug name	Blue Cross coverage criteria
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 (nortriptyline) or SSRI (Paxil, Zoloft)
Viibryd	Requires trial and failure of at least three generic or preferred antidepressant agents
Vitrakvi	Coverage requires documentation to support the following: Treatment of adult and pediatric patients with solid tumors that: 1. Have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation 2. Are metastatic or where surgical resection is likely to result in severe morbidity and 3. Do not have a satisfactory alternative treatment or that have progressed following treatment.
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.
Vizimpro	Coverage requires documentation to support the following: Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test

Drug name	Blue Cross coverage criteria
Vosevi	Coverage requires documentation to support the following: 1. Age 18 years or older 2. 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. 3. 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. 4. Trial and failure to preferred medication: Epclusa or Zepatier 5. Documentation of previous treatments for Hepatitis C 6. Documentation of compensated or decompensated cirrhosis 7. Written by a hepatologist, gastroenterologist, or infectious disease specialist 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)

Drug name	Blue Cross coverage criteria
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	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis in adults 2. Trial and failure of one disease-modifying antirheumatic drug (DMARD) (Examples include methotrexate, sulfasalazine, azathioprine) Or 1. Diagnosis of psoriatic arthritis 2. Trial and failure of one DMARD. Examples include methotrexate, sulfasalazine, azathioprine Or 1. Diagnosis of ulcerative colitis 2. Trial and treatment failure or intolerance to conventional therapies (corticosteroids, immunomodulator)

Drug name	Blue Cross coverage criteria
Xeljanz XR	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis in adults 2. Trial and failure of one disease-modifying antirheumatic drug (DMARD) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine) Or 1. Diagnosis of psoriatic arthritis 2. Trial and failure of one DMARD. Examples include methotrexate, sulfasalazine, azathioprine
Xelpros	Coverage requires documentation to support the following: 1. Treatment of elevated intraocular pressure 2. Trial and treatment failure of two preferred medications such as generic Xalatan, Lumigan or Travatan Z.
Xenical	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia. Maximum benefit is limited to 24 months of treatment.
Xepi	Coverage requires documentation to support the following: 1. Diagnosis of impetigo 2. Trial of generic Bactroban

Drug name	Blue Cross coverage criteria
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

Drug name	Blue Cross coverage criteria
Xospata	Coverage requires documentation to support the following: Treatment of relapsed or refractory acute myeloid leukemia (AML) in adult patients with an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an approved test
Xuriden	Coverage required documentation to support the following: 1. Diagnosis of Hereditary Orotic Aciduria. 2. Prescribed by or in consultation with an endocrinologist or geneticist.
Xyosted	Coverage requires documentation to support the following: 1. Diagnosis of hypogonadism 2. Two signs and symptoms specific to testosterone deficiency

Drug name	Blue Cross coverage criteria
Xyrem	Coverage requires documentation to support a diagnosis of narcolepsy and: 1. Cataplexy demonstrated by supporting chart documentation or sleep studies Or 1. Excessive daytime sleepiness supported by chart documentation or sleep studies and 2. Age ≥ 7 years old but less than 18 years 3. Trial of at least one generic or preferred treatment such as methylphenidate or dextroamphetamine Or 1. Age ≥ 18 years old 2. Trial of modafinil in doses up to 400mg daily 3. Trial of at least one generic or preferred treatment such as methylphenidate or dextroamphetamine Xyrem will not be approved if patient is being treated with sedative hypnotic agents, other CNS depressants or using alcohol
Yonsa	Coverage requires documentation of the following: FDA approved indications
Zejula	Coverage requires documentation to support the following: 1. Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer 2. Complete or partial response to platinum-based chemotherapy Initial approval: 1 year Renewal: Documentation noting absence of disease progression Renewal – annually

Drug name	Blue Cross coverage criteria
Zelboraf	Coverage requires documentation to support following: 1. Diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation. Or 2. Diagnosis of Erdheim-Chester Disease with BRAF V600 mutation Initial approval – 1 year Renewal: Documentation noting absence of disease progression Renewal – Annually
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. Documentation of previous treatment experience for Hepatitis C 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.

Drug name	Blue Cross coverage criteria
Zetonna	Coverage 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.

Drug name	Blue Cross coverage criteria
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	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

Drug name	Blue Cross coverage criteria
Zurampic	Coverage requires documentation to support the following: 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 generic and preferred XOI.
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: 3 months Renewal criteria: Documentation of recurrence and or new lesions. Renewal approval: 3 months
Zydelig	Coverage requires documentation to support the following: 1. Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab. Or 2. Relapsed follicular B-cell non-Hodgkin lymphoma (FL) and have received at least two prior systemic therapies. Or 3. Relapsed small lymphocytic lymphoma (SLL) and have received at least two prior systemic therapies

Drug name	Blue Cross coverage criteria
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.