## **ABIRATERONE\_NVT\_2020**

### **Products Affected**

* *abiraterone acetate*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Urologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ACNE AGENTS\_NVT\_2020**

### **Products Affected**

* *adapalene external cream*
* *adapalene external gel*
* *adapalene-benzoyl peroxide*
* AVITA
* DIFFERIN EXTERNAL LOTION
* EPIDUO FORTE
* *tretinoin external*
* *tretinoin microsphere*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ACTEMRA\_NVT\_2020**

### **Products Affected**

* ACTEMRA ACTPEN
* ACTEMRA SUBCUTANEOUS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For rheumatoid arthritis and polyarticular juvenile idiopathic arthritis: Intolerance to or failure of therapy with Humira AND Enbrel. For Giant Cell Arteritis: trial and failure of corticosteroids required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Rheumatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ACTIMMUNE\_NVT\_2020**

### **Products Affected**

* ACTIMMUNE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Hematologist, Immunologist, or Genetic Specialist |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ADCIRCA\_NVT\_2020**

### **Products Affected**

* ALYQ
* *tadalafil (pah)*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ADEMPAS\_NVT\_2020**

### **Products Affected**

* ADEMPAS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **AFINITOR\_NVT\_2020**

### **Products Affected**

* AFINITOR
* AFINITOR DISPERZ

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist or an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ALECENSA\_NVT\_2020**

### **Products Affected**

* ALECENSA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ALINIA\_NVT\_2020**

### **Products Affected**

* ALINIA ORAL SUSPENSION RECONSTITUTED
* ALINIA ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For diarrhea due to giardiasis, trial of metronidazole is required. For diarrhea due to cryptosporidiosis, trial of metronidazole not required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ALUNBRIG\_NVT\_2020**

### **Products Affected**

* ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
* ALUNBRIG ORAL TABLET THERAPY PACK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ANDROGENS\_NVT\_2020**

### **Products Affected**

* ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR
* *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Morning testosterone levels, from two separate days, fall below the normal range for a healthy adult male. For patients already on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **APTIOM\_NVT\_2020**

### **Products Affected**

* APTIOM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ARCALYST\_NVT\_2020**

### **Products Affected**

* ARCALYST

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Rheumatology Specialist, Dermatology Specialist, or Immunologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ARIKAYCE\_NVT\_2020**

### **Products Affected**

* ARIKAYCE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has failed to achieve negative sputum cultures after at least 6 months of multidrug regimen therapy for MAC lung disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with, an Infectious Disease Specialist or Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ARIPIPRAZOLE\_NVT\_2020**

### **Products Affected**

* *aripiprazole oral solution*
* *aripiprazole oral tablet dispersible*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient is unable to swallow tablets AND Patient has tried and failed or was intolerant to risperidone ODT or solution AND olanzapine ODT or solution. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ARIXTRA\_NVT\_2020**

### **Products Affected**

* *fondaparinux sodium*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | Body weight less than 50 kg (venous thromboembolism prophylaxis only). |
| **Required Medical Information** | If prescribed for acute DVT, patient must have a trial with or contraindication to enoxaparin. For all other FDA-approved indications, trial of enoxaparin not required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **AURYXIA\_NVT\_2020**

### **Products Affected**

* AURYXIA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **AUSTEDO\_NVT\_2020**

### **Products Affected**

* AUSTEDO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For tardive dyskinesia: Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease: Patient has intolerance to or failure of therapy with tetrabenazine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist or Psychiatrist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BALVERSA\_NVT\_2020**

### **Products Affected**

* BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with, an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BAXDELA\_NVT\_2020**

### **Products Affected**

* BAXDELA ORAL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist. |
| **Coverage Duration** | Approved for 6 months subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BENLYSTA\_NVT\_2020**

### **Products Affected**

* BENLYSTA SUBCUTANEOUS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | Member has active lupus nephritis OR severe active CNS lupus OR member is taking IV cyclophosphamide or other biologics. |
| **Required Medical Information** | For initial therapy: Member is required to be taking a concurrent corticosteroid unless contraindicated AND has trial and failure of one (1) of the following: hydroxychloroquine, methotrexate, azathioprine OR mycophenolate. For continuation therapy: documentation of disease improvement is required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Rheumatologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | For initial therapy: Diagnosis of active systemic lupus erythematosus is defined by anti-double stranded DNA value of greater than 30 IU/mL OR low complement (C3/C4). For continuation therapy: lab values not required. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BENZNIDAZOLE\_NVT\_2020**

### **Products Affected**

* *benznidazole*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist. |
| **Coverage Duration** | Approved for 3 months subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BOSULIF\_NVT\_2020**

### **Products Affected**

* BOSULIF

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BRAFTOVI\_NVT\_2020**

### **Products Affected**

* BRAFTOVI ORAL CAPSULE 75 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **BRIVIACT\_NVT\_2020**

### **Products Affected**

* BRIVIACT ORAL SOLUTION
* BRIVIACT ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CABOMETYX\_NVT\_2020**

### **Products Affected**

* CABOMETYX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CALQUENCE\_NVT\_2020**

### **Products Affected**

* CALQUENCE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient was intolerant to ibrutinib (Imbruvica) |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CAPRELSA\_NVT\_2020**

### **Products Affected**

* CAPRELSA ORAL TABLET 100 MG, 300 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Endocrinologist or Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CARBAGLU\_NVT\_2020**

### **Products Affected**

* CARBAGLU

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CAYSTON\_NVT\_2020**

### **Products Affected**

* CAYSTON

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist or Pulmonology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CERDELGA\_NVT\_2020**

### **Products Affected**

* CERDELGA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with, a Clinical Genetics specialist and/or a Medical Biochemical Genetics specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CESAMET\_NVT\_2020**

### **Products Affected**

* CESAMET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CGRP\_CLUSTER\_HA\_NVT\_2020**

### **Products Affected**

* EMGALITY (300 MG DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of episodic cluster headache AND has tried and failed verapamil. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Neurologist or Headache Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CGRP\_NVT\_2020**

### **Products Affected**

* AIMOVIG
* EMGALITY

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has tried and failed a 3-month or greater trial of 2 of the 3 following drug classes: anticonvulsants, vasoactive agents, antidepressants. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Neurologist or Headache Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Headache specialist defined as a member of the United Council for Neurologic Subspecialties, American Headache Society, National Headache Foundation, or International Headache Society OR has a certificate of added qualification in headache medicine or by the American Board of Headache Management. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CHOLBAM\_NVT\_2020**

### **Products Affected**

* CHOLBAM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hepatologist or Pediatric Gastroenterologist. |
| **Coverage Duration** | Initial will be 3 months, then if criteria is met approved for the rest of the plan year. |
| **Other Criteria** | Renewal requires documentation of stable or improved liver function. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CIMZIA\_NVT\_2020**

### **Products Affected**

* CIMZIA PREFILLED
* CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with Humira AND Enbrel. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx.For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla.For Crohn's Disease: Intolerance to or failure of therapy with Humira. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease : Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **COMETRIQ\_NVT\_2020**

### **Products Affected**

* COMETRIQ (100 MG DAILY DOSE)
* COMETRIQ (140 MG DAILY DOSE)
* COMETRIQ (60 MG DAILY DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **COPIKTRA\_NVT\_2020**

### **Products Affected**

* COPIKTRA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CORLANOR\_NVT\_2020**

### **Products Affected**

* CORLANOR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Cardiology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **COSENTYX\_NVT\_2020**

### **Products Affected**

* COSENTYX (300 MG DOSE)
* COSENTYX SENSOREADY (300 MG)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methotrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **COTELLIC\_NVT\_2020**

### **Products Affected**

* COTELLIC

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **CYSTARAN\_NVT\_2020**

### **Products Affected**

* CYSTARAN

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For the treatment of corneal cystine crystal accumulation in patients with cystinosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Ophthalmologist or Medical Geneticist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **DALFAMPRADINE\_NVT\_2020**

### **Products Affected**

* *dalfampridine er*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **DAURISMO\_NVT\_2020**

### **Products Affected**

* DAURISMO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **DOPTELET\_NVT\_2020**

### **Products Affected**

* DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG(15 PACK)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For chronic immune thrombocytopenia: Prescribed by, or in consultation with a Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **DRONABINOL\_NVT\_2020**

### **Products Affected**

* *dronabinol*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **DUPIXENT\_NVT\_2020**

### **Products Affected**

* DUPIXENT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Atopic Dermatitis: Intolerance to, or failure of therapy of two (2) of the following: a medium to very high potency topical steroid, a topical calcineurin inhibitor OR an oral immunosuppressant. For Asthma: Prescriber attests that member has a history, within the last year, of at least 1 asthma exacerbation requiring one of the following: treatment with systemic corticosteroids OR emergency department visit OR hospitalization. |
| **Age Restrictions** | For Atopic Dermatitis: Member must be 12 years of age or older. For Asthma: Member must be 12 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Allergist, Immunologist, Pulmonologist, Dermatologist or ENT Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) body surface area involvement of 10 percent or more OR chart documentation of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. 2) At least two (2) of the following: intractable pruritus (itching), cracking and oozing/bleeding of skin, OR impaired activities of daily living. For asthma: Member has moderate to severe asthma with an eosinophilic phenotype (documented baseline blood eosinophil concentration greater than or equal to 150 cells/mL) OR member has oral corticosteroid-dependent asthma. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ENBREL\_NVT\_2020**

### **Products Affected**

* ENBREL MINI
* ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
* ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
* ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ENDARI\_NVT\_2020**

### **Products Affected**

* ENDARI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **EPCLUSA\_NVT\_2020**

### **Products Affected**

* *sofosbuvir-velpatasvir*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments. |
| **Age Restrictions** | Member must be 18 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. |
| **Coverage Duration** | Coverage duration of 12 weeks. |
| **Other Criteria** | Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **EPIDIOLEX\_NVT\_2020**

### **Products Affected**

* EPIDIOLEX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Trial of at least 1 anti-epileptic medication was ineffective or not tolerated. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by a Neurologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ERIVEDGE\_NVT\_2020**

### **Products Affected**

* ERIVEDGE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Trial of Odomzo required for locally advanced basal cell carcinoma. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ERLEADA\_NVT\_2020**

### **Products Affected**

* ERLEADA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Urologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FANAPT\_NVT\_2020**

### **Products Affected**

* FANAPT
* FANAPT TITRATION PACK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FARYDAK\_NVT\_2020**

### **Products Affected**

* FARYDAK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FASENRA\_NVT\_2020**

### **Products Affected**

* FASENRA
* FASENRA PEN

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). |
| **Age Restrictions** | Member must be 12 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FERRIPROX\_NVT\_2020**

### **Products Affected**

* FERRIPROX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FIRMAGON\_NVT\_2020**

### **Products Affected**

* FIRMAGON

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Urologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **FYCOMPA\_NVT\_2020**

### **Products Affected**

* FYCOMPA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **GALAFOLD\_NVT\_2020**

### **Products Affected**

* GALAFOLD

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation that member has an amenable glactosidase alpha gene (GLA) variant. |
| **Age Restrictions** | Member must be 16 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Medical Geneticist or a prescriber specialized in the treatment of Fabry disease. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **GATTEX\_NVT\_2020**

### **Products Affected**

* GATTEX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dependent on parenteral support for at least 12 months and at least 3 days per week. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **GILOTRIF\_NVT\_2020**

### **Products Affected**

* GILOTRIF

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **GROWTH HORMONES\_NVT\_2020**

### **Products Affected**

* GENOTROPIN
* GENOTROPIN MINIQUICK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HAE AGENTS\_NVT\_2020**

### **Products Affected**

* BERINERT
* CINRYZE
* FIRAZYR
* HAEGARDA
* RUCONEST
* TAKHZYRO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HETLIOZ\_NVT\_2020**

### **Products Affected**

* HETLIOZ

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient is totally blind. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HOFH\_NVT\_2020**

### **Products Affected**

* JUXTAPID

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Lipidologist, Cardiologist, or an Endocrinologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HRM ANTIDEPRESSANT\_NVT\_2020**

### **Products Affected**

* *amitriptyline hcl oral*
* *amoxapine*
* *clomipramine hcl oral*
* *desipramine hcl oral*
* *doxepin hcl oral capsule*
* *doxepin hcl oral concentrate*
* *imipramine hcl oral*
* *imipramine pamoate*
* *paroxetine hcl er*
* *paroxetine hcl oral tablet*
* PAXIL ORAL SUSPENSION
* PEXEVA
* *protriptyline hcl*
* *trimipramine maleate oral*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Requires trial and failure of one of the following: SSRI (not including paroxetine), SNRI, OR bupropion. For diagnosis of nocturnal enuresis, trial and failure of other agents not required. |
| **Age Restrictions** | PA applies to members 65 years or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HRM DISOPYRAMIDE\_NVT\_2020**

### **Products Affected**

* *disopyramide phosphate oral*
* NORPACE CR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Requires trial and failure of one of the following: beta-blocker, calcium channel blockers, OR flecainide. |
| **Age Restrictions** | PA applies to members 65 years or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **HUMIRA\_NVT\_2020**

### **Products Affected**

* HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
* HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
* HUMIRA PEN-CD/UC/HS STARTER
* HUMIRA PEN-PS/UV/ADOL HS START
* HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. For Ankylosing Spondylitis (AS) or Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate OR sulfasalazine. (Trial of methotrexate or sulfasalazine not required for AS with predominant axial involvement). For Ulcerative Colitis or Crohn's Disease: Requires failure of, or intolerance to one of the following: corticosteroid, azathioprine, methotrexate OR 6-mercaptopurine. For Hidradenitis Suppurativa (HS): patient must have at least 3 cysts AND failure of therapy with at least one (1) oral antibiotic. For Uveitis: Requires failure of, or intolerance to thearpy with a corticosteroid AND an immunosuppressant (methotrexate, mycophenolate mofetil, azathioprine, OR cyclosporine). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS):Prescribed by, or in consultation with a Dermatology Specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. For Uveitis: Prescribed by, or in consultation with a Rheumatology specialist OR ophthalmologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IBRANCE\_NVT\_2020**

### **Products Affected**

* IBRANCE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ICLUSIG\_NVT\_2020**

### **Products Affected**

* ICLUSIG ORAL TABLET 15 MG, 45 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IDHIFA\_NVT\_2020**

### **Products Affected**

* IDHIFA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation of IDH2 mutation as detected by an FDA approved test. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IM ANTIPSYCHOTICS (ALLY ALIGN\_2020)**

### **Products Affected**

* ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
* ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
* ARISTADA
* ARISTADA INITIO
* INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
* INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
* PERSERIS
* RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has established tolerability with the oral version of medication being requested. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IMATINIB\_NVT\_2020**

### **Products Affected**

* *imatinib mesylate*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IMBRUVICA\_NVT\_2020**

### **Products Affected**

* IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
* IMBRUVICA ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist, Hemotologist, or Transplant specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **INCRELEX\_NVT\_2020**

### **Products Affected**

* INCRELEX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **INGREZZA\_NVT\_2020**

### **Products Affected**

* INGREZZA ORAL CAPSULE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has failed to respond to a change, or is unable to switch current antidopaminergic therapy AND has a functional disability due to tardive dyskinesia. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a neurologist or psychiatrist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **INLYTA\_NVT\_2020**

### **Products Affected**

* INLYTA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **INREBIC\_NVT\_2020**

### **Products Affected**

* INREBIC

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hematologist or an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **INVEGA\_NVT\_2020**

### **Products Affected**

* *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Previous agent trials not required for schizoaffective disorder. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IPF\_NVT\_2020**

### **Products Affected**

* ESBRIET
* OFEV

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Will not be used in combination with other medications used to treat IPF. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IRESSA\_NVT\_2020**

### **Products Affected**

* IRESSA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ITRACONAZOLE\_NVT\_2020**

### **Products Affected**

* *itraconazole oral capsule*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For onychomycosis, must fail terbinafine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist, Pulmonary Specialist, or Dermatology Specialist. |
| **Coverage Duration** | Approved for 6 months. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **IVIG\_NVT\_2020**

### **Products Affected**

* FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
* GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
* GAMMAGARD S/D LESS IGA
* GAMMAKED INJECTION SOLUTION 1 GM/10ML
* GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
* GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
* OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
* PANZYGA
* PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Approval will be based off BvD coverage determination. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **JAKAFI\_NVT\_2020**

### **Products Affected**

* JAKAFI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hematologist or an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **JYNARQUE\_NVT\_2020**

### **Products Affected**

* JYNARQUE ORAL TABLET
* JYNARQUE ORAL TABLET THERAPY PACK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has an eGFR of 25 ml/min/1.73m2 or greater. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Nephrologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **KALYDECO\_NVT\_2020**

### **Products Affected**

* KALYDECO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **KEVZARA\_NVT\_2020**

### **Products Affected**

* KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Intolerance to or failure of therapy with Humira AND Enbrel. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Rheumatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **KISQALI\_NVT\_2020**

### **Products Affected**

* KISQALI (200 MG DOSE)
* KISQALI (400 MG DOSE)
* KISQALI (600 MG DOSE)
* KISQALI FEMARA (400 MG DOSE)
* KISQALI FEMARA (600 MG DOSE)
* KISQALI FEMARA(200 MG DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **KORLYM\_NVT\_2020**

### **Products Affected**

* KORLYM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **KUVAN\_NVT\_2020**

### **Products Affected**

* KUVAN

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Medical Geneticist or Metabolic Physician. |
| **Coverage Duration** | Initial approval of 3 months, then if critieria is met, approved for the rest of the contract year. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LENVIMA\_NVT\_2020**

### **Products Affected**

* LENVIMA (10 MG DAILY DOSE)
* LENVIMA (12 MG DAILY DOSE)
* LENVIMA (14 MG DAILY DOSE)
* LENVIMA (18 MG DAILY DOSE)
* LENVIMA (20 MG DAILY DOSE)
* LENVIMA (24 MG DAILY DOSE)
* LENVIMA (4 MG DAILY DOSE)
* LENVIMA (8 MG DAILY DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LETAIRIS\_NVT\_2020**

### **Products Affected**

* *ambrisentan*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Cardiologist or Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LEUKINE\_NVT\_2020**

### **Products Affected**

* LEUKINE INJECTION SOLUTION RECONSTITUTED

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Trial of or intolerance to filgrastim-sndz (Zarxio) AND tbo-filgrastim (Granix). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LIDOCAINE PATCH\_NVT\_2020**

### **Products Affected**

* *lidocaine external patch 5 %*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Trial and failure of gabapentin of four weeks or more. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LIDOCAINE TOPICAL\_NVT\_2020**

### **Products Affected**

* *lidocaine external ointment*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Trial and failure of topical lidocaine 2% gel/jelly. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LINZESS\_NVT\_2020**

### **Products Affected**

* LINZESS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LONSURF\_NVT\_2020**

### **Products Affected**

* LONSURF

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LORBRENA\_NVT\_2020**

### **Products Affected**

* LORBRENA ORAL TABLET 100 MG, 25 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **LYNPARZA\_NVT\_2020**

### **Products Affected**

* LYNPARZA ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MAVYRET\_NVT\_2020**

### **Products Affected**

* MAVYRET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments. |
| **Age Restrictions** | Member must be 12 years of age or older, or weigh at least 45kg. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician. |
| **Coverage Duration** | Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance. |
| **Other Criteria** | Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MEGESTROL SUSP\_NVT\_2020**

### **Products Affected**

* *megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MEGESTROL TABS\_NVT\_2020**

### **Products Affected**

* *megestrol acetate oral tablet*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MEKINIST\_NVT\_2020**

### **Products Affected**

* MEKINIST ORAL TABLET 0.5 MG, 2 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MEKTOVI\_NVT\_2020**

### **Products Affected**

* MEKTOVI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **MOVANTIK\_NVT\_2020**

### **Products Affected**

* MOVANTIK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NATPARA\_NVT\_2020**

### **Products Affected**

* NATPARA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Endocrinologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NERLYNX\_NVT\_2020**

### **Products Affected**

* NERLYNX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NEXAVAR\_NVT\_2020**

### **Products Affected**

* NEXAVAR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | Member must be 18 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NINLARO\_NVT\_2020**

### **Products Affected**

* NINLARO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NORTHERA\_NVT\_2020**

### **Products Affected**

* NORTHERA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NOXAFIL\_NVT\_2020**

### **Products Affected**

* NOXAFIL ORAL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NUBEQA\_NVT\_2020**

### **Products Affected**

* NUBEQA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Urologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NUCALA\_NVT\_2020**

### **Products Affected**

* NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Asthma diagnosis: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). For eosinophilic granulomatosis with polyangiitis (EGPA), confirmation of diagnosis required. |
| **Age Restrictions** | Member must be 6 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Allergy Specialist, Immunologist, Pulmonary Specialist or Rheumatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NUEDEXTA (ALLY ALIGN\_2020)**

### **Products Affected**

* NUEDEXTA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation is provided (in the form of chart notes or imaging) of a structural neurological condition as the cause of pseudobulbar affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with, a Neurologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Member has tried and failed an SSRI. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NUPLAZID\_NVT\_2020**

### **Products Affected**

* NUPLAZID ORAL CAPSULE
* NUPLAZID ORAL TABLET 10 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **NUVIGIL\_NVT\_2020**

### **Products Affected**

* *armodafinil*
* *modafinil*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **OCALIVA\_NVT\_2020**

### **Products Affected**

* OCALIVA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Hepatologist or Gastroenterologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ODOMZO\_NVT\_2020**

### **Products Affected**

* ODOMZO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **OLUMIANT\_NVT\_2020**

### **Products Affected**

* OLUMIANT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Intolerance to or failure of therapy with Humira AND Enbrel. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Rheumatology specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **OPSUMIT\_NVT\_2020**

### **Products Affected**

* OPSUMIT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Cardiologist or Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ORAL FENTANYL\_NVT\_2020**

### **Products Affected**

* *fentanyl citrate buccal*
* FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Breakthrough cancer pain and opioid tolerance. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ORENITRAM\_NVT\_2020**

### **Products Affected**

* ORENITRAM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ORFADIN\_NVT\_2020**

### **Products Affected**

* ORFADIN

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ORILISSA\_NVT\_2020**

### **Products Affected**

* ORILISSA ORAL TABLET 150 MG, 200 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has failure to, or intolerance to a non-steroidal anti-inflammatory drug (NSAID) AND a hormonal contraceptive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an obstetrician/gynecologist or women's health/reproductive specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Member does not have known osteoporosis. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ORKAMBI\_NVT\_2020**

### **Products Affected**

* ORKAMBI ORAL PACKET
* ORKAMBI ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist. |
| **Coverage Duration** | Initial and continuation approval of 6 months to assess required medical info. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **OSPHENA\_NVT\_2020**

### **Products Affected**

* OSPHENA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Intolerance to or failure of therapy with generic estradiol vaginal cream and PREMARIN VAGINAL CREAM. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **OTEZLA\_NVT\_2020**

### **Products Affected**

* OTEZLA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). For Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PALYNZIQ\_NVT\_2020**

### **Products Affected**

* PALYNZIQ

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | Member is 18 years of age or older. |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Medical Geneticist or Metabolic Physician. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PCSK9\_NVT\_2020 \*\*Pending CMS Review\*\***

### **Products Affected**

* PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
* PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR
* REPATHA
* REPATHA PUSHTRONEX SYSTEM
* REPATHA SURECLICK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For initiation of therapy patient must: A) Have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria) 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria) or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) Current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). Criteria B) not required for HoFH. For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), 3) HoFH (see Other Criteria), or 4) Primary hyperlipidemia other than HeFH and HoFH (see Other Criteria) AND B) member had 10% or greater reduction in LDL-C on PCSK9 inhibitor therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger. Diagnosis of primary hyperlipidemia (other than HeFH and HoFH) |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PIQRAY\_NVT\_2020**

### **Products Affected**

* PIQRAY (200 MG DAILY DOSE)
* PIQRAY (250 MG DAILY DOSE)
* PIQRAY (300 MG DAILY DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation of HR +/HER2- and PIK3CA-mutation: Used in combination with fulvestrant: Used following progession on or after an endocrine-based therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by Hematologist or Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **POMALYST\_NVT\_2020**

### **Products Affected**

* POMALYST

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **POSACONAZOLE**

### **Products Affected**

* *posaconazole*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids |
| **Required Medical Information** | Diagnosis of one of the following A.) Oropharyngeal candidiasis, or B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection |
| **Age Restrictions** | 13 years of age and older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |

## **POTASSIUM BINDERS\_NVT\_2020**

### **Products Affected**

* LOKELMA
* VELTASSA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has baseline persistent potassium level greater than 5.0 mmol/L. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Nephrologist, Cardiologist, or Endocrinologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PREVYMIS\_NVT\_2020**

### **Products Affected**

* PREVYMIS ORAL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PROGESTERONE\_NVT\_2020**

### **Products Affected**

* CRINONE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PROLIA\_NVT\_2020**

### **Products Affected**

* PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For osteoporosis: Trial of an oral bisphosphonate was not tolerated. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PROMACTA\_NVT\_2020**

### **Products Affected**

* PROMACTA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **QBRELIS\_NVT\_2020**

### **Products Affected**

* QBRELIS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Approval requires attestation of patient's inability to swallow solid dosage forms of lisinopril. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **RAVICTI\_NVT\_2020**

### **Products Affected**

* RAVICTI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Requires trial of sodium phenylbutyrate powder. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Metabolic Physician or Medical Geneticist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **RELISTOR\_NVT\_2020**

### **Products Affected**

* RELISTOR SUBCUTANEOUS SOLUTION

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient, member must have tried and failed lactulose. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for 4 months, subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **REVATIO\_NVT\_2020**

### **Products Affected**

* *sildenafil citrate oral tablet 20 mg*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **REVLIMID\_NVT\_2020**

### **Products Affected**

* REVLIMID

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **REXULTI\_NVT\_2020**

### **Products Affected**

* REXULTI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For schizophrenia, patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. For Major Depressive Disorder, patient has tried and failed or was intolerant to aripiprazole. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **RINVOQ**

### **Products Affected**

* RINVOQ

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of moderate to severe rheumatoid arthritis and patient has had an inadequate reponse or intolerance to methotrexate. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 months |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |

## **ROZLYTREK**

### **Products Affected**

* ROZLYTREK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of one of the following: A) ROS1-positive metastatic non-small cell lung cancer (NSCLC), OR B) Solid tumors that 1) have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, AND 2) are metastatic or where surgical resection is likely to result in severe morbidity, AND 3) have either progressed following treatment or have no satisfactory alternative therapy |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |

## **RUBRACA\_NVT\_2020**

### **Products Affected**

* RUBRACA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **RYDAPT\_NVT\_2020**

### **Products Affected**

* RYDAPT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SABRIL\_NVT\_2020**

### **Products Affected**

* *vigabatrin*
* VIGADRONE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SAPHRIS\_NVT\_2020**

### **Products Affected**

* SAPHRIS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SIGNIFOR\_NVT\_2020**

### **Products Affected**

* SIGNIFOR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Endocrinologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SIMPONI\_NVT\_2020**

### **Products Affected**

* SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
* SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with Humira AND Enbrel. For Ankylosing Spondylitis (AS): Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel OR Cosentyx. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of thearpy with Humira. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SIRTURO\_NVT\_2020**

### **Products Affected**

* SIRTURO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SIVEXTRO\_NVT\_2020**

### **Products Affected**

* SIVEXTRO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist. |
| **Coverage Duration** | Approved for 6 months subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SKYRIZI\_NVT\_2020**

### **Products Affected**

* SKYRIZI (150 MG DOSE)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR soriatane. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SOLARAZE\_NVT\_2020**

### **Products Affected**

* *diclofenac sodium transdermal gel 3 %*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SOLTAMOX\_NVT\_2020**

### **Products Affected**

* SOLTAMOX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SOMAVERT\_NVT\_2020**

### **Products Affected**

* SOMAVERT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Endocrinologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SPRITAM\_NVT\_2020**

### **Products Affected**

* SPRITAM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member must have a trial or contraindication to generic levetiracetam. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SPRYCEL\_NVT\_2020**

### **Products Affected**

* SPRYCEL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **STELARA\_NVT\_2020**

### **Products Affected**

* STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
* STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Plaque Psoriasis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx, Skyrizi OR Otezla.For Crohn's Disease: Intolerance to or failure of therapy with Humira. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Crohn's Disease: Prescribed by, or in consultation with a Gastroenterology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **STIVARGA\_NVT\_2020**

### **Products Affected**

* STIVARGA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SUCRAID\_NVT\_2020**

### **Products Affected**

* SUCRAID

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SUTENT\_NVT\_2020**

### **Products Affected**

* SUTENT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SYLATRON\_NVT\_2020**

### **Products Affected**

* SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SYMDEKO\_NVT\_2020**

### **Products Affected**

* SYMDEKO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Pulmonologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SYMPROIC\_NVT\_2020**

### **Products Affected**

* SYMPROIC

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **SYPRINE\_NVT\_2020**

### **Products Affected**

* *trientine hcl*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TAFINLAR\_NVT\_2020**

### **Products Affected**

* TAFINLAR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TAGRISSO\_NVT\_2020**

### **Products Affected**

* TAGRISSO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TALZENNA\_NVT\_2020**

### **Products Affected**

* TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TARCEVA\_NVT\_2020**

### **Products Affected**

* *erlotinib hcl*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TARGRETIN\_NVT\_2020**

### **Products Affected**

* *bexarotene*
* TARGRETIN EXTERNAL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TASIGNA\_NVT\_2020**

### **Products Affected**

* TASIGNA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TAVALISSE\_NVT\_2020**

### **Products Affected**

* TAVALISSE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TETRABENAZINE\_NVT\_2020**

### **Products Affected**

* *tetrabenazine*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has chorea due to Huntington's Disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **THALOMID\_NVT\_2020**

### **Products Affected**

* THALOMID

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Infectious Disease Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TIBSOVO\_NVT\_2020**

### **Products Affected**

* TIBSOVO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TOBI\_NVT\_2020**

### **Products Affected**

* TOBI PODHALER
* *tobramycin inhalation*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Approval will be based off BvD coverage determination. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TOPICAL STEROIDS\_NVT\_2020**

### **Products Affected**

* *amcinonide external cream*
* *amcinonide external ointment*
* BESER EXTERNAL LOTION
* *betamethasone valerate external foam*
* *clobetasol propionate emulsion*
* *clobetasol propionate external foam*
* *clobetasol propionate external liquid*
* *clobetasol propionate external lotion*
* *clobetasol propionate external shampoo*
* CLODAN EXTERNAL SHAMPOO
* *desonide external cream*
* *desonide external lotion*
* *fluticasone propionate external lotion*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Requires trial of two formulary topical steroids. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TPO AGONISTS\_NVT\_2020**

### **Products Affected**

* MULPLETA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for 1 month subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TRACLEER\_NVT\_2020**

### **Products Affected**

* *bosentan*
* TRACLEER ORAL TABLET SOLUBLE

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TRIKAFTA**

### **Products Affected**

* TRIKAFTA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of cystic fibrosis and patient has at least 1 F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist or prescribing practioner is from a CF center accredited by the Cystic Fibrosis Foundation |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |

## **TROKENDI\_NVT\_2020**

### **Products Affected**

* QUDEXY XR
* *topiramate er*
* TROKENDI XR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome OR is using for prophylaxis of migraine headache. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TURALIO\_NVT\_2020**

### **Products Affected**

* TURALIO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **TYKERB\_NVT\_2020**

### **Products Affected**

* TYKERB

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has received prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **UCERIS\_NVT\_2020**

### **Products Affected**

* *budesonide er oral tablet extended release 24 hour*
* UCERIS RECTAL

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **UPTRAVI\_NVT\_2020**

### **Products Affected**

* UPTRAVI ORAL TABLET
* UPTRAVI ORAL TABLET THERAPY PACK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VALCHLOR\_NVT\_2020**

### **Products Affected**

* VALCHLOR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has received prior skin-directed therapy such as topical steroids. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VASCEPA\_NVT\_2020**

### **Products Affected**

* VASCEPA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hypertriglyceridemia: Documentation of persistent triglycerides above 500 mg/dL AND trial of, or intolerance to omega-3 acid ethyl esters. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a lipidologist or cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VENCLEXTA\_NVT\_2020**

### **Products Affected**

* VENCLEXTA
* VENCLEXTA STARTING PACK

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VENTAVIS\_NVT\_2020**

### **Products Affected**

* VENTAVIS

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis confirmed by right heart catheterization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Pulmonologist or Cardiologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VERZENIO\_NVT\_2020**

### **Products Affected**

* VERZENIO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VITRAKVI\_NVT\_2020**

### **Products Affected**

* VITRAKVI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation of NTRK gene fusion mutation required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VIZIMPRO\_NVT\_2020**

### **Products Affected**

* VIZIMPRO

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VORICONAZOLE\_NVT\_2020**

### **Products Affected**

* *voriconazole intravenous*
* *voriconazole oral*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Physician or Oncologist. |
| **Coverage Duration** | Approved for 6 months subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VOSEVI\_NVT\_2020**

### **Products Affected**

* VOSEVI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments. |
| **Age Restrictions** | Member must be 18 years of age or older. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician. |
| **Coverage Duration** | Coverage duration of 12 weeks. |
| **Other Criteria** | Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VOTRIENT\_NVT\_2020**

### **Products Affected**

* VOTRIENT

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VRAYLAR\_NVT\_2020**

### **Products Affected**

* VRAYLAR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has tried and failed or was intolerant to 2 of the following: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **VYNDAMAX**

### **Products Affected**

* VYNDAMAX

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of wild type or hereditary transthyretin related familial amyloid cardiomyopathy |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a cardiologist |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |

## **XALKORI\_NVT\_2020**

### **Products Affected**

* XALKORI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XATMEP\_NVT\_2020**

### **Products Affected**

* XATMEP

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For polyarticular juvenile idiopathic arthritis: patient must have trial of or inability to use oral methotrexate tablet. For acute lymphoblastic leukemia: trial of oral methotrexate tablet is not required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XELJANZ\_NVT\_2020**

### **Products Affected**

* XELJANZ

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Rheumatoid Arthritis (RA): Intolerance to or failure of therapy with Humira AND Enbrel. For Psoriatic Arthritis: Intolerance to or failure of therapy with 2 of the following: Humira, Enbrel, Cosentyx OR Otezla. For Ulcerative Colitis: Intolerance to or failure of therapy with Humira. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | For Rheumatoid Arthritis or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis : Prescribed by, or in consultation with a Gastroenterology Specialist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XGEVA\_NVT\_2020**

### **Products Affected**

* XGEVA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XIFAXAN (ALLY ALIGN\_2020)**

### **Products Affected**

* XIFAXAN ORAL TABLET 200 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XIFAXAN 550MG\_NVT\_2020**

### **Products Affected**

* XIFAXAN ORAL TABLET 550 MG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required. |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XOLAIR\_NVT\_2020**

### **Products Affected**

* XOLAIR

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) , AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contradindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment. |
| **Age Restrictions** | If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old. |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Allergy Specialist, Pulmonary Specialist, Dermatology Specialist or Immunologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XOSPATA\_NVT\_2020**

### **Products Affected**

* XOSPATA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation of FLT3 mutation required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XPOVIO\_NVT\_2020**

### **Products Affected**

* XPOVIO (100 MG ONCE WEEKLY)
* XPOVIO (60 MG ONCE WEEKLY)
* XPOVIO (80 MG ONCE WEEKLY)
* XPOVIO (80 MG TWICE WEEKLY)

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Documentation of prior therapies required and include at least 4 therapies, including at least 2 proteasome inhibitors, 2 immunomodulatory agents and an anti-CD38 monoclonal antibody. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Hematologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XTANDI\_NVT\_2020**

### **Products Affected**

* XTANDI

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For metastatic castration-resistant prostate cancer (mCRPC), failure of or intolerance to abiraterone (Zytiga equivalent) required. For nonmetastatic castration-resistant prostate cancer (nmCRPC), failure of or intolerance to apalutamide (Erleada) required. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Urologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XULTOPHY\_NVT\_2020**

### **Products Affected**

* XULTOPHY

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with a maximally dosed GLP-1 receptor agonist or basal insulin greater than or equal to thirty (30) units per day, OR member is currently using basal insulin AND a GLP-1 receptor agonist. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **XYREM\_NVT\_2020**

### **Products Affected**

* XYREM

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Neurologist, Pulmonologist, or Sleep Medicine Physician. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZAVESCA\_NVT\_2020**

### **Products Affected**

* *miglustat*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with a Medical Geneticist, Hematologist, or Metabolic Physician. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZEJULA\_NVT\_2020**

### **Products Affected**

* ZEJULA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZELBORAF\_NVT\_2020**

### **Products Affected**

* ZELBORAF

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZOLINZA\_NVT\_2020**

### **Products Affected**

* ZOLINZA

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist or Dermatologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZYDELIG\_NVT\_2020**

### **Products Affected**

* ZYDELIG

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZYKADIA\_NVT\_2020**

### **Products Affected**

* ZYKADIA ORAL TABLET

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Oncologist. |
| **Coverage Duration** | Approved for duration of contract year subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **ZYVOX (ALLY ALIGN2020)**

### **Products Affected**

* *linezolid intravenous solution 600 mg/300ml*
* *linezolid oral*

| **PA Criteria** | **Criteria Details** |
| --- | --- |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by, or in consultation with an Infectious Disease Specialist. |
| **Coverage Duration** | Approved for 6 months subject to formulary change and member eligibility. |
| **Other Criteria** | N/A |
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |

## **PART B VERSUS PART D**

### **Products Affected**

* ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
* *acetylcysteine inhalation solution 10 %, 20 %*
* *acyclovir sodium intravenous solution 50 mg/ml*
* *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
* AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
* AMINOSYN II INTRAVENOUS SOLUTION 10 %
* AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %
* *amphotericin b intravenous solution reconstituted 50 mg*
* *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
* ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
* ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML
* ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
* AZASAN ORAL TABLET 100 MG, 75 MG
* *azathioprine oral tablet 50 mg*
* *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
* *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
* *calcitriol oral solution 1 mcg/ml*
* *cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg*
* CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
* CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
* CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
* CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
* CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
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* *cyclophosphamide oral capsule 25 mg, 50 mg*
* *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
* *cyclosporine modified oral solution 100 mg/ml*
* *cyclosporine oral capsule 100 mg, 25 mg*
* *dextrose intravenous solution 10 %*
* *dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %*
* *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
* *doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg*
* *duramorph injection solution 0.5 mg/ml, 1 mg/ml*
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* *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*
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* INTRALIPID INTRAVENOUS EMULSION 20 %
* *ipratropium bromide inhalation solution 0.02 %*
* *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
* *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml*
* *levocarnitine oral solution 1 gm/10ml*
* *levocarnitine oral tablet 330 mg*
* *mycophenolate mofetil oral capsule 250 mg*
* *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
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* NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
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* *ondansetron hcl oral solution 4 mg/5ml*
* *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
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* PREMASOL INTRAVENOUS SOLUTION 10 %, 6 %
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## **Details**

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

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